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Cape Town, 26 January 1952

Weekly 2s

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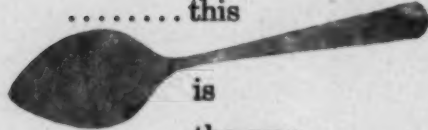
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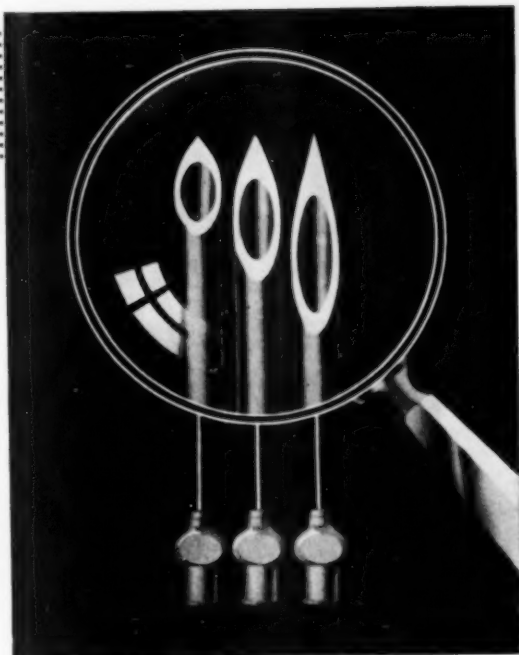
★**R**EFERENCE Slack, H. G. B. and
Wilkinson, J. F. (1949): Lancet i 11.

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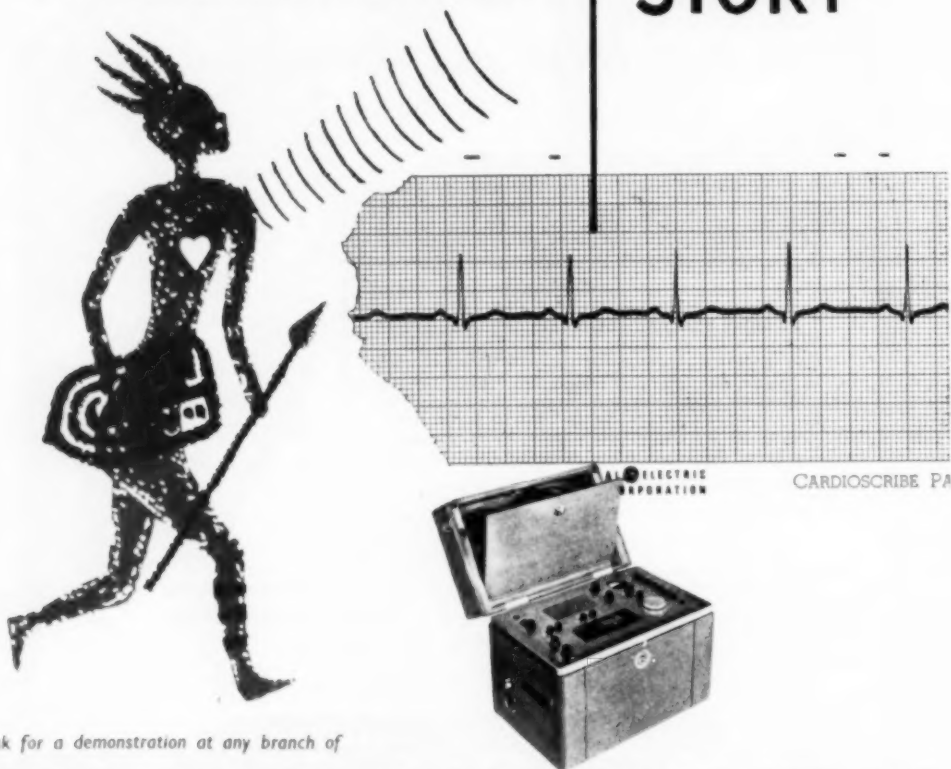
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NOTES ON THE TRAINING OF SOUTH AFRICAN DOCTORS

A. SIMPSON WELLS, M.B. (CAPE TOWN), M.A., M.D. (GLASGOW), F.R.C.S. (EDIN.)*

Cape Town

The question of medical education has recently been the subject of much study and many communications have been made on this topic to medical journals the world over.

Until 1922 our country was entirely dependent on medical practitioners trained overseas, chiefly in the United Kingdom. In 1922 the University of Cape Town granted medical degrees to two students. In 1939 there were 86 and in 1949, 184 graduates in medicine. In 1949 also, 154 students graduated in medicine at the University of the Witwatersrand and 109 in Pretoria University, a total of 447 medical graduates in the Union in that year. The importance of medical education has not been lost sight of by our Governments and in 1939 a Committee¹ and in 1950 a Commission² (both appointed by the Government) have reported on aspects of medical education.

It is unnecessary to dwell on the importance of the quality of medical men to any country and especially in South Africa, where practice has often to be carried on in isolated districts.

Verax, capax, sagax, perspicax, efficax, tenax. These are the qualities required by the lone-hand practitioner, but also by all. Prof. T. J. Mackie³ stressed this aspect when he said: 'Medical education is not a matter of mere academic interest but concerns the country as a whole and the welfare of the people.' An important question then arises. What is the 'raw material' both in quality and quantity from which the medical schools have to turn out good doctors?

There are difficulties which arise in the choice of applicants who are to be allowed to enter the medical faculty. There are at present in South Africa more applicants than vacancies and in the United Kingdom a recent publication, *The Training of a Doctor*, reports that at one medical school there were 10 applicants for each vacancy. In our Universities, the present plan seems to be to admit only those who have obtained a first-class pass in the Senior Certificate or Matriculation examinations. It is obvious that the 'first-class matric.' standard is not sufficient and leaves out important questions (aptitude, character, etc.). It is to be hoped that some form of interview may solve this problem.

* Honorary lecturer in obstetrics, University of Cape Town.

In an Education Number of the *South African Medical Journal*⁴ there is an article under the title 'Sal ek doktor wees?' from the brilliant pen of the late Dr. C. L. Leipoldt. He writes: 'Hierdie bogestelde vraag is een wat menig pas geslaagde matriculant waarskynlik vir homself reeds gestel het. Die antwoord hang af van wat hy hom voorgestel het wat die werk en die roeping van 'n dokter in die medisyne eintlik is. . . . Nogtans behoort hy sekere punte in ernstige oorweging te neem voordat hy besluit om hom te laat inskryf vir 'n opleiding wat ten minste ses jare vir sy voleinding neem. . . . Ons het ten minste 'n honderd goeie dokters elke jaar nodig.' This wise advice (of which only a part can be quoted) should be studied by parents, sons and daughters before a decision is made.

The financial outlay required to obtain a medical degree has been variously estimated at a sum of from £1,500 to £2,000. This applies to students in South Africa and is dependent on whether a student is living at home, has long journeys to make, keeps a car, etc., or not.

It is not unknown for medical students to contract debts in order to pay their way when at the University. Such debts may be a crippling burden during early years of practice. 'Should fees of medical students be economic?' is a question raised in the *Medical Record* in the early days of our medical school. The Report of the Royal College of Physicians, London,⁵ on Medical Education (and in which many valuable recommendations are made) concludes with the advice that all University education should be free. This, of course, is part of the 'Welfare State' conception and in theory, at least, is sound. Financial considerations should not be allowed to stand between suitable students and service of their fellows as medical practitioners. At present the grants by the Government to the Universities in the United Kingdom are on a much more generous scale than in South Africa and carry no interference.

The question how far our school education, even when a 'first-class matric.' has been gained, really gives a sufficient cultural background to a medical student, needs consideration. The idea has been put forward that, in view of the ever-growing scientific medical knowledge, the student should pass the 'pre-medical' scientific subjects (biology, chemistry and physics) before entrance into the University. This has not been a success, when tried.

'There should be no vocational bias in pre-University studies' is a sound rule. Dr. Lindsay Sandes⁶ has made a strong plea for a year of general University studies, including the humanities, before the medical course is commenced.

In the Report of the Committee on Medical Training in South Africa¹ the idea of students taking an Arts or Science degree, before commencing the medical studies, has been advocated.

In view of the length of the medical course (six years at least) and also of the many additional years of study required of those who specialize, these must be looked upon as highly desirable plans, but counsels of perfection. At it, it is not unusual to find the world over, resentment on the part of medical students at the first-year courses and by the same token some of the teachers to whom these courses are entrusted, take a poor view of this task.

The writer has obtained from some of his old students impressions of the medical course at the University of Cape Town from which a few extracts have been made:

'The teaching (in botany) seemed to have little relation to the wider field of medicine. Most students become tired of it because they could not see its practical application.' 'Chemistry appeared to dominate the first year. A great deal of ground was covered at rather a rapid rate.' 'The first year was very busy. Considerable adjustment to changes from methods of study in school to those of the university was required.'

In *The Training of a Doctor*,⁷ it is stated:

'The fundamental purpose of the course of basic sciences is to teach scientific method and inculcate habits of clear and logical thinking. The professor or a senior member on the staff should take a specific and direct supervision over the preparation of the syllabus and teaching and should take an interest in the general welfare of the first year class.'

The importance of co-ordinated planning was also stressed in a valuable review of our medical education in our own *Journal*⁸ in 1949. It is important that continuity should be given to the whole medical course. Thus one graduate writes: anatomy 'was well taught'. 'It is a great pity that after the second year one's anatomy was not used directly till the fifth year.' In *The Training of a Doctor*⁷ it is recommended that a clinician should co-operate in the teaching of anatomy.

Dr. F. M. R. Walshe⁹ in an important article on the integration of medical study, discussing the teaching of physiology, refers to the fact that physiologists commonly, naturally pursue their science for its own sake. 'In medicine we have to apply knowledge to well-defined ends—the health and well-being of the community.'

One graduate writes: 'Pharmacology became a monotonous chain of drugs, actions, doses. The subject was one to be remembered, and then forgotten after the examination.'

It seems incredible that such a criticism could be applied to a branch of study throbbing with the most marvellous advances since the foundation of the world. There was no word of linking pharmacology with therapeutics as practised on sick persons.

One of our graduates writes, referring to the obstetrical lectures which begin in the third year: 'Obstetrics was well taught. The one misfortune is that at this stage one had no introduction to medicine or surgery. The obstetrical practical course clashes with other classes.' The importance for our South African students to have

a sound obstetrical training is evident. Owing to the isolated nature of many practises in our country, with resulting great difficulty in transporting maternity cases, it is essential that our young doctors should be well up in this branch. There is a danger that teachers in the department of medicine, and in other subjects, are apt to emphasize the last detail of laboratory and other forms of expert investigation, not making full use of the 'unaided senses'. The systematic lecture is apt to take the place of tutorial classes at the bedside.

A successful general practitioner writes: 'The classes were already far too large. Sub-groups under clinical lecturers very seldom allowed for efficient personal attention by the lecturer, whether instruction was at the bedside or out-patient department. Instruction in the case of minor ill health was completely overlooked, the major interest being focussed on major illness.'

In a book 'G.P.', published in England,¹⁰ a practitioner writes: 'I suppose I had probably to watch 500 surgical operations before I qualified, yet I had no intention of becoming a consulting surgeon. On the other hand, I do not remember seeing a single case of whooping cough or influenza taught upon.'

In the fifth year, in addition to Medicine, Surgery, Gynaecology and Obstetrics, Public Health Medical Jurisprudence, Venereal Disease, Psychiatry, Ear, Throat and Nose diseases and Dermatology, all have to be studied. There is criticism of the lack of inter-relationship between the subjects taught and small wonder if teachers and students alike are at times disappointed.

The reports on medical education to which reference has been made give important statistical and other information.

TABLE A: NUMBER OF MEDICAL STUDENTS REGISTERED WITH THE COUNCIL ON 31 DECEMBER OF THE YEARS INDICATED

	Medical Students			
	Cape Town	Witwatersrand	Pretoria	Total
1934 ..	—	—	—	783
1935 ..	—	—	—	877
1936 ..	—	—	—	961
1937 ..	—	—	—	877
1938 ..	—	—	—	950
1939 ..	—	—	—	1055
1940 ..	—	—	—	1136
1941 ..	—	—	—	1189
1942 ..	—	—	—	1202
1943 ..	—	—	—	1287
1944 ..	644	602	198	1442
1945 ..	599	582	285	1466
1946 ..	759	654	372	1735
1947 ..	802	829	414	2045
1948 ..	811	766	422	1999
1949 ..	828	856	468	2152
1950 ..	781	784	436	2001

Table A gives statistics of numbers of medical students, and to these must be added registered first-year medical students at other non-medical teaching centres in the Union. In 1939 there were 75 such students in the Union.

Figures from Table B from the report of the Commit-

TABLE B: THE ELIMINATION OF MEDICAL STUDENTS DURING THE SIX YEARS' COURSE (UNIVERSITY OF CAPE TOWN)

	First Year	Second Year	Third Year	Fourth Year	Fifth Year	Sixth Year	Number Qualifying
1928-33	100	94	55	48	45	51	41
1929-34	100	81	51	40	44	47	33
1930-35	100	92	74	57	54	64	46
1931-36	100	74	64	44	43	59	44
1932-37	100	77	57	46	46	58	40
1933-38	100	76	66	52	51	68	46
1934-39	100	70	63	60	60	70	—

UNIVERSITY OF WITWATERSRAND							
1928-33	100	71	54	44	43	61	44
1929-34	100	62	46	41	41	52	27
1930-35	100	72	49	47	46	58	38
1931-36	100	73	45	45	44	55	42
1932-37	100	73	59	51	47	57	45
1933-38	100	65	59	55	57	65	50
1934-39	100	58	56	51	53	59	—

tee¹ (1939) indicate a heavy wastage varying from 33% to 50% of students who fall out during the six years' course. This is partly caused, especially in the earlier years, by the fact that certain students have gone overseas to complete their course. The figures, however, produce the impression that there is considerable loss to the State and to individual students, and also frustration and disappointment. This would indicate the value of a strict standard of admission of students to the Medical Faculty. A favourable impression is produced as the figures seem to indicate that a high standard is being set.

TABLE C: COMPARATIVE FIGURES

	Cape Town	Pretoria	Witwatersrand
Number of Students in the Clinical Part of the Course During 1948	531	309	479
Normal Number in the Clinical Part of Course at Proposed Number of 100 Admissions per Annum	300	300	300
Number of Students per Clinical Unit (Firm) During 1948	41	24	30
Normal Number of Students per Clinical Unit (Firm) at the Proposed Number of 100 Admissions per Annum	25	25	25

Table C is taken from the Report of the Commission² referred to and indicates the wise advice that the number of students to be admitted to the clinical part of the medical course should be restricted to 100 in each of the three Universities and that the normal number of students in each clinical unit should not exceed 25.

The Committee¹ in 1939 came to the conclusion that:

'with the present accommodation, equipment and staff at the disposal of our medical schools, there is no doubt whatever that they are seriously overcrowded'.

The Groote Schuur Hospital is the only medical unit in South Africa, built as a 'teaching hospital'; yet here, too, there is evidence of overcrowding.

It is difficult to determine how many new members of the profession are required each year. Dr. Leipoldt⁴ put the figure at 100 in 1935. If sufficient medical services were available for the eight million Natives, many more practitioners would be required than at present. It is hoped that the Medical School for Natives in Durban, strongly favoured by the medical profession, will supply the medical needs of their people. It appears that the supply of medical men recently qualified now exceeds the demand in South Africa. It has been argued that as the medical faculties are evidently overcrowded there is need for yet another medical school. The better solution seems to be to restrict the number of medical students in our three medical faculties. If this is done, as recommended (Table C), sufficient graduates would still be available. It is pleasant to record the successful founding of a Medical Faculty in the University of Pretoria as recommended by the medical profession and by the Committee.¹

All medical practitioners should be bilingual. The writer remembers how, at a Medical Congress in Pretoria, the late General Hertzog recounted to some of us members how, when he was a boy, when the doctor was called, they were all told they must speak English. With great good humour he recounted how this added to the embarrassment of a medical examination. The writer agrees with the decision of the Committee¹ and of the Commission on the question of a Medical Faculty at Stellenbosch. The Report of the former reads: 'On account of the lack of hospital facilities, Stellenbosch is precluded from being considered.'

Under the heading *The University of Stellenbosch* the opinion of the Commission² was expressed as follows:

'The authorities of this University submitted a memorandum emphasizing the need of a fourth medical school in South Africa and added that they considered that Stellenbosch had a strong claim to this school provided the necessary clinical facilities could be found.

The claim of a University with the standing of Stellenbosch to a medical school is indisputable as far as the academic part of the course is concerned. We could not, however, gain the conviction that it will be able to satisfy the requirements of clinical teaching. The proposal to use the new hospital which is expected to be erected at Bellville, 20 miles from Stellenbosch, is not regarded as acceptable.

'Stellenbosch could, however, render a valuable service to the country if it concentrated on pre-clinical courses such as the Cambridge University offers.'

On the assumption that a further medical school is required, the Commission favoured Bloemfontein as a possible site, if clinical facilities are eventually provided. The figures given in this article indicate that for many years the teaching facilities will be sufficient. A further medical school would weaken those already meeting our country's needs and built up at great cost and effort.

POST-GRADUATE STUDY AND SPECIALIZATION

It can safely be said that the present University Medical Faculties, overstrained as they are in dealing with medical students, are in no position to undertake teaching of

graduates. It is desirable that those training for specialization and also general practitioners, should have easy access in our country to post-graduate study. An excellent suggestion has been made that Port Elizabeth with its fine medical institutions would be suitable for a post-graduate school.

A feature of the medical profession at present is the large (far too large) number of our graduates who aim at being specialists and consultants. We are in danger of having too many officers and too few privates in our army. General practice, in view of the marvellous advances in modern treatment, should offer many attractions to our recent graduates. The 'G.P.' as a healer, guide, philosopher and friend of his patients can offer far greater services to his fellow citizens than ever before.

In conclusion, as recorded by the writer,¹¹ the South African Medical Association took an active part in the promotion of the Medical Faculty in its beginnings. It is important that our Medical Schools should not become isolated from the members of the medical profession.

The criticisms recorded in this article must not be taken to mean that our Universities are turning out inefficient doctors. Far from it. Our students have given evidence of sound training, when many have offered themselves for examination for advanced degrees overseas.

In the war, and in practice in the Union, Rhodesia and elsewhere they have proved sound and efficient members of the medical profession. Plans are at present on foot for improving clinical teaching and the newly decreed year as an intern will help our graduates to add to their good record.

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INCREDIBILIA

The following item is reprinted in its entirety from *Readers' Quiz*, in the *Cape Argus* of 20 December 1951:—

'Why does a person appear blue when cold and red when hot?' (T. D., Claremont.)

In strenuous exercise the blood becomes impure and causes the heart to work harder and the warm red blood to rush through the arteries. When a person is hot the blood expands and shows through the skin.

When a person is cold the red blood contracts and the impure, dark blood shows up, as the veins in the face and hands are near the surface. Thus a person looks 'blue with cold'.

ABSTRACTS

Comparison of Vitamin B₁₂ from Liver and from Streptomyces griseus in the Treatment of Pernicious Anaemia. L. A. Erf and B. Wimer (1949): *Blood*, **4**, 857.

Vitamin B₁₂ from liver and Vitamin B₁₂ from *Streptomyces griseus* were found to produce similar clinical results when dosages of the same magnitude were given to patients with pernicious anaemia in relapse, indicating that Vitamin B₁₂ is the single or at least the principal active anti-anaemic factor in liver extract. Ingestion of cobalt chloride had little or no effect on blood levels in hypoplastic anaemia and leukaemia.

Effectiveness of Vitamin B₁₂ in Combined System Disease. L. Berk, D. Denny-Brown, M. Finland and W. B. Castle (1948): *New Eng. Med. J.*, **239**, 328 (*J.A.M.A.*, 1949, **139**, 181).

Haematological remission and rapid regression of neurological manifestations occurred when a patient previously receiving inadequate doses of synthetic folic acid was treated with crystalline Vitamin B₁₂. The patient had had severe local and systemic sensitivity reactions to purified liver extract but showed no reactions to Vitamin B₁₂.



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(g) TAMPOVAGAN WITH STILBOESTROL AND SULPHATHIAZOLE
 Indications:
 Senile vaginitis, B. coli infections, hypo-oestrogenised function, etc.

South African Medical Journal

Suid-Afrikaanse Tydskrif vir Geneeskunde

VAN DIE REDAKSIE

DIE PES-BASIL

'n Onlangse uitgawe van *The Chronicle of the World Health Organization*¹ bevat 'n belangrike opsomming van die verskillende soorte pes-basil. Die bestaan van verskeie rasse wat onderskei kan word op grond van hul biochemiese eienskappe, soos byvoorbeeld inwerking op gliserien en die nitrate, is gedurende die afgelope paar jaar deur verskeie skrywers aangetoon. Die *P. pestis*-rasse van Midde-Afrika is onlangs deur Devignat² bestudeer. Hy omskryf 3 soorte.

Soort 1 (wat in die Ooste voorkom), wat gliserien nie laat gis nie, maar salpetersuur vorm;

Soort 2 (wat in Midde-Asië en in Midde-Afrika voorkom), wat gliserien laat gis en salpetersuur vorm;

Soort 3 (wat in die Suid-Ooste van Rusland voorkom), wat gliserien laat gis en nie salpetersuur vorm nie.

Nadat hy die waarde van die verskillende biochemiese reaksies wat hierdie onderskeiding moontlik maak, bespreek, beklemtoon Devignat die ooreenkomst in die maniere waarop pes oorgedra en immuniteit verkry word. Hy oorweeg die moontlikheid van permutasies tussen die soorte, maar dit bly nog 'n onuitgemaakte saak. Hy gaan die huidige geografiese verspreiding van die drie soorte na asook hul gedrag in die verlede en die rol wat hulle gespeel het by die ontstaan en in die ontwikkeling van die verskeie epidemies wat sedert die vroegste tye aangeteken is.

Soort 1, die bronne waarvan in Indië, Birma en Suid-China voorkom, was tot dusver die voorwerp van die mees omvattende studie. Dit is hierdie soort wat die pes in die Ooste veroorsaak en wat die pandemie van 1894 tot gevolg gehad het. Hierdie soort is ook verantwoordelik vir die pes wat in die bosryke gebied van Kalifornië en Suid-Afrika voorkom en op die platteland van Suid-Amerika.

Soort 2 (wat miskien die oudste soort is) het in Midde-Asië ontstaan (Transbaikalië, Mongolië en Mantsjoerie) en het met die Ariesse inval weswaarts versprei. Dit het die pes onder die Filistyne veroorsaak. Dit wil voorkom asof dit later langs die Nyl-vallei na Midde-Afrika versprei het en kolle agtergelaat het wat vandag nog voortbestaan. Dit is ook hierdie soort wat in die sesde eeu terug gewyk het na die Middellandse See en wat, na bekeer word, aanleiding gegee het tot die beroemde Justiniaanse pes wat dwarsdeur die Romeinse Ryk versprei het. Dit wil voorkom asof dit sedertdien uit Europa verdwyn en in Afrika afgesluit gebly het.

Soort 3 wat moontlik die vrug van 'n stadige vorming van soort 2 kan wees, het vermoedelik in die

EDITORIAL

THE PLAGUE BACILLUS

A recent issue of *The Chronicle of the World Health Organization*¹ contains an important summary of the varieties of the plague bacillus.

The existence of various strains distinguishable by their biochemical characteristics, such as action on glycerine and nitrates, has been demonstrated by several authors in the course of the past few years. Devignat² has recently studied the *P. pestis* strains of Central Africa. He defines 3 varieties:

Variety I (oriental), which does not ferment glycerine but produces nitrous acid;

Variety II (central Asiatic and central African) which ferments glycerine and produces nitrous acid;

Variety III (from south-east Russia), which ferments glycerine and does not produce nitrous acid.

After discussing the value of the various biochemical reactions permitting this differentiation, Devignat emphasizes the similarity of the roles in plague transmission and immunology. He considers the possibility of permutations between the varieties, but this still remains an open question.

The present geographical distribution of the three varieties is reviewed, together with their historical behaviour and their role in the origin and progress of the various epidemics recorded since antiquity.

Most study has been concentrated on variety I, the primary foci of which are found in India, Burma, and South China. It is the pathogenic agent of oriental plague, which caused the 1894 pandemic. It is also responsible for the foci of sylvatic plague in California and South Africa, and of rural plague in South America.

Variety II (perhaps the oldest) came from Central Asia (Transbaikalia, Mongolia and Manchuria) and moved west with the Aryan invasions. It was the cause of the plague among the Philistines. Later it appears to have followed the valley of the Nile into Central Africa, leaving foci which still remain to-day. It is this variety also which, moving back towards the Mediterranean in the sixth century, is believed to have provoked the famous 'Justinian plague' which spread throughout the Roman Empire. Since then it seems to have disappeared from Europe and has remained isolated in Africa.

Variety III, which might be the result of a slow transformation of variety II, seems to have spread in the 14th

1. Chron. World Hlth. Org., (1951): 5, 268.

2. Bull. World Hlth. Org. (1951): 4, 247.

1. Chron. World Hlth. Org., 1951, 5, 268.

2. Bull. World Hlth. Org., 1951, 4, 247.

14e eeu van die Kaspiese See af dwarsdeur Europa versprei, waar dit die 'Swart Dood' veroorsaak het en waar dit, deur die swart rot, oor 'n tydperk van vier eeue, inheems geword het.

Devignat se beskouing is dat die drie soorte *Pasturella* (of *Yersinia*) *pestis*, *Srt. orientalis*, *antiqua* en *mediaevalis* onderskeidelik, genoem kan word. Hy stel 'n stelselmatige en wêreldwye biochemiese studie van al die rasse van die pes-basil voor.

century from the Caspian Sea throughout the whole of Europe, where it caused the 'Black Death' and, through the black rat, established itself endemically during four centuries.

Devignat considers that these three varieties of *Pasteurella* (or *Yersinia*) *pestis* could be named var. *orientalis*, *antiqua*, and *mediaevalis* respectively. He proposes a systematic world-wide biochemical study of all plague strains.

TROPICAL ULCERS OF THE LEG AND NAIL BED

AUREOMYCIN OINTMENT IN THEIR TREATMENT

A. H. LASBREY, M.B., Ch.B.

McCord Zulu Hospital, Durban

Tropical (sloughing phagedena) ulcers are seen frequently in African children in Durban and less often in adults. The lesion, though usually small, and associated with only a little cellulitis, is sufficiently painful and persistent to bring the patients to the doctor repeatedly. A trial treatment with Aureomycin ointment brought about so dramatic a response that an investigation was instituted.

This series of 74 cases is presented to illustrate a simple, effective, inexpensive, ambulant treatment for the smaller tropical ulcer. Not a single case, including three with serological evidence of syphilitic disease, failed to show an immediate response to treatment and 34 cases returned to show the completely epithelialized ulcer. Sixty ulcers were on the leg or foot and 14 on the nail bed of the toe.

SELECTION OF CASES

With a few exceptions the patients were young Bantu people, living under poor conditions on the outskirts of Durban. The majority were between eight and 20 years of age.

Cases were selected on the typical appearance of the tropical (sloughing phagedena) ulcer. The nail-bed tropical ulcer is described in detail because it is often not recognized. The larger nail-bed ulcer resembles the tropical ulcer of the leg more closely than does the smaller ulcer.

NAIL-BED ULCER

Situation: Occupying the nail bed of any of the toes.

Shape: Circular or oval.

Size: Varies from $\frac{1}{4}$ -1 inch in its largest diameter.

Edge: Usually slightly raised.

Discharge: Sero-purulent or purulent, grey or greyish-green in colour and often sanguineous.

Surface: Usually covered with discharge and encrusted dirt.

Base: Unhealthy, pale, irregular granulations and sloughs.

Odour: Often offensive.

The necrotic remnant of the nail, usually $\frac{1}{4}$ inch in width, bounds the proximal end of the ulcer. The terminal phalanx is usually swollen to one and a half times its normal size. The ulcer is very painful.

Bacterial Flora of the Ulcers. Eleven nail-bed ulcers were swabbed before treatment and in all but one case Vincent's spirochaetes and fusiform bacilli were found on direct examination, after rapid staining with carbol fuchsin.

In eight cases cocci were found on culture on McConkey's medium and blood agar and in one, diphtheroids. The coccal organisms found, varied unpredictably and included the following organisms: *Staphylococcus aureus*, coagulase-positive and coagulase-negative; haemolytic streptococci and non-haemolytic streptococci; *Staphylococcus albus* and diplococci. Gram-negative bacilli were occasionally found. Two cases were swabbed before the second and third dressings and no organisms were found on direct examination. In one, cocci were isolated on culture before the second dressing, and Vincent's spirochaetes, and fusiform bacilli before the fourth dressing (18 days after treatment had commenced); but five days later the ulcer had epithelialized completely. This was the only occasion on which these organisms were isolated from an ulcer after the first application of Aureomycin. It is interesting to note that the sister of this child was treated concurrently for a lesion in the mouth, with small white plaques on the mucosa and mild pyrexia and cellulitis of the cheek. Identical organisms, Vincent's spirochaetes and fusiform bacilli, were found on examination of a swab, taken from one of the plaques and the lesion responded to oral Aureomycin therapy.

Of the ulcers on the leg or foot, 35 were swabbed before the first dressing. On direct examination Vincent's spirochaetes were found in 26 cases and fusiform bacilli in 31 cases. On culture cocci were isolated from 12 cases and diphtheroids from five cases.

In five cases swabs were taken before the second dressing and in none were Vincent's spirochaetes isolated and a few fusiform bacilli in one.

In the two cases swabbed before the third dressing no organisms were found.

One case of a large ulcer of six months' duration (not included in the series) was hospitalized for a few days for the purpose of taking repeated swabs. The initial dressing was lifted and replaced but not changed when each swab was taken. Bacteriological results were as follows:

1. Before application of the Aureomycin dressing fusiform bacilli were found on direct examination, coagulase-positive *Staphylococcus aureus* and non-haemolytic streptococci were isolated on culture.

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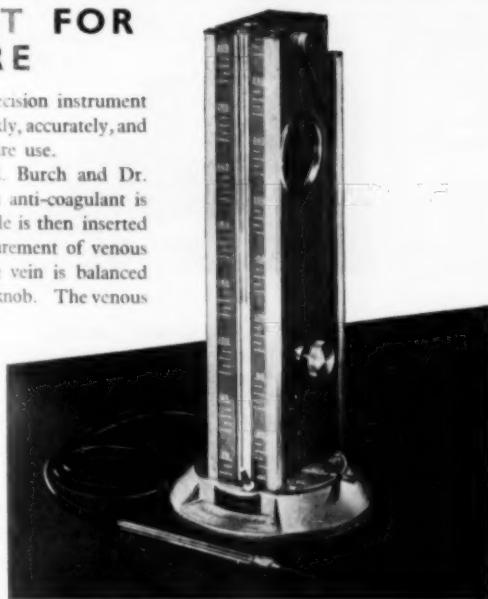
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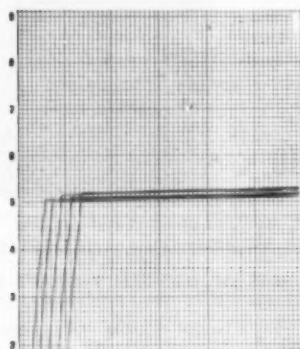
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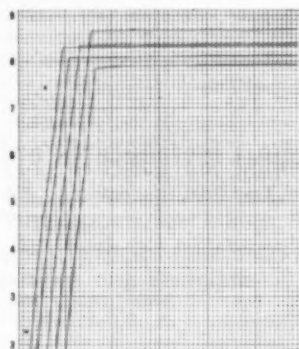
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2. Six hours, 12 hours, 18 hours and 24 hours later fusiform bacilli were found on examination. Cultures were sterile.

3. Thirty-six and 48 hours later, no organisms were found on direct examinations and cultures were sterile.

The Wassermann reaction of the blood was negative in 23 cases and positive in three cases. Healing in these cases was not delayed.

Method of Treatment. A swab was taken from the ulcer. The discharge and slough was wiped away with a swab soaked in saline or eusol solution. The base of the ulcer was then wiped with a dry swab. Aureomycin ointment was applied sparingly on a piece of dry gauze. A small pad of cotton wool and a gauze bandage completed the dressing. In nail-bed ulcers the necrotic remnant of the nail was not removed. No other treatment was given.

Expense. In treating ulcers varying in size from $\frac{1}{4}$ -2½ inches in diameter a ½-oz. tube of Aureomycin ointment lasted for an average of 30 dressings. Each dressing would thus have cost approximately 3½d. with the ½-oz. tube costing 8s. (hospital price, August 1951, in Durban).

Frequency of Dressings. Patients were instructed to return at intervals of five days; but in fact the intervals varied between three and 14 days, as all the patients were ambulant and at school or work.

Response to Treatment. Details of the results of treatment in 30 of the cases which returned to show the completely epithelialized ulcer are given in Tables I and II. Approximately 30 other cases stopped coming for dressings when the ulcer had reduced to half its original size or smaller.

TABLE 1: TROPICAL ULCERS OF LEG AND FOOT

S = Vincent's Spirochaetes		F = Fusiform Bacilli		C = Cocci		D = Diphtheroids		N.O. = No Organisms		
Case Number	Patient	Age (Years)	Wassermann Reaction	Duration of Ulcer	Size (Diameters) in Inches	Days taken to Epithelize Completely	Number of Dressings	Bacterial Flora of Ulcer		
								Before 1st Dressing	Before 2nd Dressing	Before 3rd Dressing
1	M. H.	15	Positive	3 weeks	$\frac{1}{4}$	3	1	S. F. C.		
2	S. L.	18	Negative	1 week	$\frac{1}{4}$	5	1			
3	M. N.	6			$\frac{1}{4}$	5	1	S. F. C.		
4	L. M.	9	Negative	3 months	$\frac{1}{4}$	5	1	F.		
5	M. N.	16		1 month	$\frac{1}{4}$	7	2	S. F. D.	N. O.	
6	M. W.	8		1 week	$3 \times 1\frac{1}{2}$	7	2			
7	F. N.			8 months	$1\frac{1}{2} \times 2$	7	2			
8	M. N.	16		1 month	$\frac{1}{4}$	8	2	S. F. D.		
9	V. N.	7		5 months	$\frac{1}{4} \times \frac{1}{2}$	8	2	C.		
10	G. K.	12			$\frac{1}{4}$	12	2	S. F. D.		
11	G. N.	14		15 months	$1 \times \frac{1}{2}$	13	3			
12	M. H.	15	Positive	5 months	$\frac{1}{4}$	14	4	S. F. D.	N. O.	C.
13	M. N.		Negative		$\frac{1}{4}$	16	2			
14	L. S.	13		1 month	$1 \times 1\frac{1}{2}$	18	3	S. F. C. D.		
15	B. W.	13		1 month	$\frac{1}{4}$	21	4			
16	A. Z.	15	Negative	2 weeks	$1\frac{1}{4}$	24	2	S. F. C.	C.	
17	T. N.	16	Negative	1 month	$\frac{1}{4} \times \frac{1}{2}$	24	4			
18	L. M.	9	Negative	4 months	2×1	28	6	F.		
19	Q. C.	20	Positive	3 months	$\frac{1}{4}$	30	3			
20	H. N.	8		2 weeks	$2 \times 1\frac{1}{2}$	29	5	S. F.	N. O.	
21	L. M.	9	Negative	4 months	$1 \times 1\frac{1}{2}$	32	7	F.		

TABLE 2: TROPICAL NAIL-BED ULCERS

S = Vincent's Spirochaetes		F = Fusiform Bacilli		C = Cocci		D = Diphtheroids		N.O. = No Organisms		
Case Number	Patient	Age Years	Wassermann Reaction	Duration of Ulcer	Size (Diameters) in Inches	Days taken to Epithelize Completely	Number of Dressings	Bacterial Flora of Ulcer		
								Before 1st Dressing	Before 2nd Dressing	Before 3rd Dressing
22	P. N.	3		2 weeks	$\frac{1}{4}$	4	1			
23	S. R.	4		2 weeks	$1 \times \frac{1}{2}$	5	2	S. F. C.		
24	S. R.	4		3 weeks	$\frac{1}{4}$	5	2			
25	Z. D.	7		1 year	$\frac{1}{4}$	5	1	S. F. C.		
26	V. N.	7		5 months	$\frac{1}{4}$	6	1	C.		
27	L. M.	10			$\frac{1}{4}$	6	1	S. F.		
28	S. N.				$\frac{1}{4}$	11	3			
29	J. N.	7		3 months	$1 \times \frac{1}{4}$	23	5	S. F. C.	C.	N. O.
30	A. P.	36		1½ months	1×1	26	6	S. F.	N. O.	N. O.

Thirteen of 30 ulcers were epithelialized within a week and a further seven ulcers within two weeks. The diameter of these ulcers varied from $\frac{1}{2}$ -2 inches with the exception of one which measured three inches. Their duration varied from a week to a year.

One case in which the patient went away from Durban when an ulcer measuring three inches had been reduced to only two inches, returned two months later with the ulcer larger than its original size. The organisms were again present in the discharge and an immediate response to combined local and oral therapy occurred.

A striking feature in many cases was the marked relief of pain which the patients reported as having occurred within 48 hours of the first application of Aureomycin.

It was noted consistently when the first dressing was removed, usually five days after its application, that the discharge was no longer offensive and usually had not saturated the bandages; the dressing did not adhere to the ulcer surface and thus its removal was painless. The surface of the ulcer usually appeared clean and had healthy red granulations, often with an obvious ingrowing edge of epithelium. Edges which had been heaped up were flattened and the depth of the ulcer decreased.

TYPICAL CASE HISTORIES

Case 30. On 23 June 1951, A.P., an African male aged 36 years, presented himself for treatment of a large ulcer, occupying the whole of the nail bed of the great toe and extending beyond to measure in its greatest diameter 1 inch. The edge was raised, $\frac{1}{4}$ inch of necrotic nail remained at the base; there was thick sanguineous-purulent discharge and an unhealthy granular base (Fig. 1).



Fig. 1 (Case 30). Before treatment.
Fig. 2 (Case 12). A. Original edge of ulcer.
B. Healed area.
C. Residual granulating area.
(four days after first application of Aureomycin.)

Bacteriological examination showed Vincent's spirochaetes and fusiform bacilli on direct examination and no organisms on culture. The ulcer had been present for six weeks, had been painful enough to make walking difficult and had kept him away from his work. It had been dressed in an out-patient clinic three times a week during that period.

Treatment with Aureomycin was carried out as described

above. On 28 June 1951 the size had diminished to $1 \times \frac{1}{2}$ inch, the healing edge having grown in from the distal side of the ulcer. The base was clean and the discharge serous. The patient walked without pain. No organisms were found on examination of the discharge. On 2 July 1951 the size was $\frac{1}{2} \times \frac{1}{2}$ inch. Bacteriological examination was again negative. Four more dressings were applied and on 19 July 1951 the ulcer was completely healed, 26 days after the first application of Aureomycin.

Case 25. On 14 July 1951 an African boy aged seven years complained that the ulcer on the nail bed of his second right toe had been present for a year and had shown no signs of healing in spite of repeated dressings with ointments at home. The ulcer was painful and measured $\frac{1}{2}$ inch. Vincent's spirochaetes and fusiform bacilli were seen on direct examination of the discharge and non-haemolytic streptococci were isolated on culture. He returned five days later and the ulcer was completely healed and was not tender.

Case 5. M. N., an African male aged 16 years, came to the dispensary on 11 June 1951 with a tropical ulcer 1 inch in diameter on the medial aspect of the right foot. The ulcer had been present for a month and had not been treated. Vincent's spirochaetes and fusiform bacilli were seen on direct examination of the discharge and diphtheroids were grown on culture. On 15 June 1951 the diameter of the ulcer was $\frac{1}{2}$ inch and clean pink epithelium surrounded the residual central granulation. Bacteriological examination was negative. Epithelialization was complete on 19 June 1951 when the patient came again for treatment.

Case 12. M.H., an African female aged 15 years, presented on 18 June 1951 with an ulcer of five months' duration, bound up with a filthy rag. The ulcer measured two inches in diameter. Vincent's spirochaetes and fusiform bacilli were seen on direct examination and haemolytic streptococci and coagulase-negative staphylococci were grown on culture. The blood Wassermann reaction was positive. No treatment other than the local application of Aureomycin ointment was given until the ulcer was healed.

On 21 June 1951 there was healthy smooth pink epithelium covering what had been the outer half of the ulcer and centrally an area of granulation measured less than $\frac{1}{2}$ inch. No organisms were found on examination of the discharge (Fig. 2). The third dressing was done on 26 June 1951, and on 30 June 1951 (16 days after the first application of Aureomycin) epithelialization was complete, except for an area the size of a pin-head.

DISCUSSION

In December 1950, Ampofo and Findlay¹ made a second report on the remarkable effect of the oral administration of Aureomycin on the healing of tropical ulcers. Details of eight cases treated over a period of four to seven days and observed until healing was complete showed that the organisms had disappeared from all ulcers after 72 hours' treatment. In the present series it is not known, except in the one case quoted above, how long the organisms remained, because of infrequent dressings (arranged for the convenience of workers and scholars and to reduce bus fares to a minimum); but the rapid disappearance of pain and discharge suggests a similar period.

Comparison of the details given of the size of two cases in Ampofo's series and the period which elapsed before epithelialization was complete, indicates a rate of healing approximately equal to that observed with local Aureomycin treatment. An ulcer $1\frac{1}{2} \times 1\frac{1}{2}$ inches healed in 24 days and another $1 \times 1\frac{1}{2}$ inches healed in three weeks. The advantages of oral therapy lies in its obviating the necessity for repeated visits, a factor of no mean importance in rural Africa. The Aureomycin capsules can be taken home and no local treatment other than a clean covering for the ulcer is required. Its disadvantage lies in the expense of the treatment (at present) and the undesirability

of giving a potent antibiotic which is as effective when used locally. Ampofo's¹ observation on six tropical ulcers treated with Chloramphenicol led him to conclude that Aureomycin (oral) probably gives the more consistently rapid results.

Penicillin likewise is a powerful therapeutic agent. Findlay Hill and MacPherson² treated undernourished ambulatory patients with success. Two cases in which details of size were given healed as rapidly as cases treated by oral administration of Aureomycin.

Halliman's³ results in 118 cases treated by carbolic acid and then local application of dried Torula yeast and Elastoplast and oral administration of Torula yeast, were consistently successful except in patients with a positive blood Khan test, but the impression is that healing was slower by several days.

In none of the above series were sufficient figures quoted of the rate of healing of the ulcers or of their size to make a fair comparison, particularly as observation shows that large recent ulcers sometimes heal with astounding rapidity.

SUMMARY

1. The local application of Aureomycin ointment in 74 cases of tropical (phagedenic sloughing) ulcer of the leg, foot and nail bed, proved to be an effective remedy.

2. The treatment is simple, ambulant and inexpensive, costing approximately 3½d. for each of the one to seven dressings required.

3. Healing was as rapid as has been described in any other non-surgical method of treatment.

The author wishes to thank Dr. Alan B. Taylor, Medical Superintendent of the McCord Zulu Hospital, for permission to publish the results of this investigation; Messrs. Lederle Ltd., for generously supplying Aureomycin ointment to conduct the investigation; Mr. Bates of the Union Health Department, Durban, for the bacteriological examinations, and Miss McLaggan of the Central Provincial Laboratory, Wentworth, for the photographs.

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FOETUS PAPYRACEUS

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A foetus papyraceus is formed when there is intra-uterine death of one foetus during the early months of a multiple pregnancy. This foetus is retained *in utero* and delivered at term, with its viable twin, as a dried-out, flattened, though obviously recognizable specimen. The similarity to a doll cut out of cardboard is most striking.

Although rare, it is a most interesting condition. Kindred (1944) reported two cases and culled the literature in a most exhaustive review, obtaining references to 150 cases. Amongst these, 32 were from America, 27 from England and one from South Africa.

The condition has long been known to the medical world. Pliny (A.D. 23-79) is reputed to have mentioned it in his early writings and Ramsbottom (1860) notes that the condition has been recorded in textbooks of the 16th century.

Much of the early work and description of these cases came from medico-legal investigators. Orillia (1828) was an interested observer of the changes of maceration and mummification occurring *in utero*, as compared with those taking place in the bodies of still-born children exposed to various media such as air, gases, running and stagnant water. Settegast (1872) is reputed to have been the first to have classically designated the condition 'foetus papyraceus'. The French have called this condition, *un petit bonhomme du pain d'épice*—the little gingerbread man.

O'Regan (1941) reported a triple pregnancy in which one foetus papyraceus was delivered through a 2-finger dilated os. Nine days later active labour ensued with

the delivery of a live 7-pound child and a second foetus papyraceus embedded in the amniotic sac. Siegler (1937) reports a similar case.

O'Regan suggests that the condition may be more common than is generally suspected and easily missed if the amniotic sac is not carefully inspected, this being especially so if the foetus has died during the early months of pregnancy. Against this is the fact that a foetus dying before the eighth week is usually completely absorbed and also that, in any teaching hospital, routine careful examination of the placenta and membranes is the rule.

Engelhorn (1925) considers that it is three times more common in uniovular than binovular twins.

CLINICAL ASPECTS

The mother's health is rarely affected by the presence of the foetus papyraceus. Crosman (1936) conducting experiments on rats, where dead foetuses were tied off in one cornu to prevent abortion, records a subsequent pregnancy supervening and continuing to term. Loevsett (1933) and Thoms (1934) each record a similar case occurring in human beings.

On the other hand, however, the death of the one foetus may be the cause, or follow as a result of placental infarction and its concomitant ante-partum haemorrhage.

Sabath (1948) records haemorrhage occurring during the early weeks of pregnancy. This was chronologically correlated with the time of death of the foetus. The foetus papyraceus was delivered at term with its viable twin.

This is a similar experience to that recorded in Case 1,

*Clinical Assistant.

though here the vaginal bleeding was repeated on several occasions. The strong family history of twins raised the possibility of the condition being one of hydatidiform mole formation in one sac of a twin pregnancy. Mischler (1948) reports such a case.

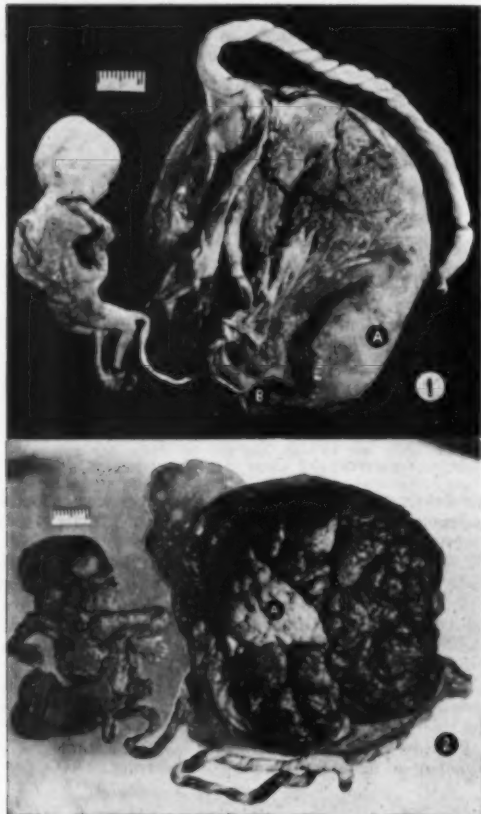


Fig. 1. Placenta with foetus papyraceus attached showing: 'A' the area of infarction, and 'B' the velamentous insertion of the cord.

Fig. 2. Placenta with foetus papyraceus attached showing the infarcted area 'A'.

In both illustrations the scale is in inches.

Terkuile (1941) reports a case of a foetus papyraceus covering the internal os like a placenta praevia. On examination through a 2-finger dilated os, a rough uneven surface with tiny sharp points was felt. X-ray examination revealed this to be a foetus papyraceus and, as labour did not progress, caesarean section was performed, disclosing the foetus papyraceus lying over the internal os—the tiny sharp points felt were the rib margins of the dried-out foetus.

Cases are on record where a foetus papyraceus has been

diagnosed *ante partum* by X-ray examination, though rarely has it necessitated any operative interference.

Leff (1948) describes a case of bleeding in the puerperium due to retention of an undeveloped secondary embryo, where the placenta and membranes were apparently complete at delivery. This cannot occur in uniovular twin pregnancies.

No effect has been observed on the viable twin, though Kindred (1944) estimated the weight of the surviving twin to be on an average $1\frac{1}{2}$ lb heavier than twins in which both were viable.

Case 1. A 36-year-old, 3rd parous, 4th gravidous, 26-weeks pregnant European with a previously normal obstetrical history, complained of repeated attacks of vaginal bleeding since the 18th week of pregnancy.

As no abnormality was detected on examination, she was diagnosed as suffering from a threatened abortion. Throughout pregnancy paroxysmal attacks of vaginal bleeding persisted.

On 24 March 1950 she came into labour prematurely, expelling a 4½-lb. female infant after a 6-hour labour. The foetal heart ceased during the second stage.

A uniovular placenta with a foetus papyraceus attached followed 10 minutes later. There was marked infarction of the placental area supplying the foetus. There was a velamentous insertion of the cord (Fig. 1).

The length of the foetus papyraceus corresponded to a 16-weeks' foetus, suggestive of death having occurred at the time of the first vaginal bleeding. The puerperium was normal. The cause of the still-born twin could not be explained. The Wassermann test was negative and the Rh factor positive.

Case 2. A 20-year-old primigravida gave normal birth at term to a live 8 lb. 12 oz. female child. The placenta with foetus papyraceus attached followed almost immediately.

The placenta was uniovular and showed infarction of the area supplying the foetus papyraceus (Fig. 2).

The ante-natal course had been entirely without incident and the puerperium was normal. The Wassermann reaction was negative and the Rh factor positive.

DISCUSSION

Foetus papyraceus cases present two interesting problems. Why should the one foetus die during the early weeks of pregnancy and why should the process of dehydration and compression occur instead of maceration?

Browne (1947) attributes the cause of death of one foetus as being due to reversal of the circulation in the hypogastric arteries of the weaker twin by its stronger companion and its placental circulation is thus brought to a standstill. Infarction of that portion of the placenta is usually seen.

Velamentous insertion of the cord has been suggested as a possible cause of death. Kindred (1944) mentions cord complications as present in over 40% of the cases reviewed by him.

The time of intra-uterine death may well be a factor in the production of a foetus papyraceus. Siegler (1937) reports a triple pregnancy in which one foetus died during the early weeks of pregnancy and was preserved as a foetus papyraceus. The second foetus died at about 30

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weeks and underwent maceration. The foetus papyraceus and the macerated, older foetus were both delivered at term with the viable third child weighing 5½ lb.

Mills (1949) reports eight cases of intra-uterine death of one twin. In two cases, where death was early on in pregnancy, a foetus papyraceus was formed. In the others death occurred in the later weeks of pregnancy, the foetuses were macerated and some liquor amnii was found in the sac. The only one of these cases to show placental infarction had a velamentous insertion of the cord.

He further maintains that compression by the sac or the head of the surviving twin causes dehydration with the arrest of maceration and the formation of a foetus papyraceus. Compression may well be a necessary factor, as similar changes in the dead foetus of a single pregnancy have not been reported.

Crosman (1936) in a study of the dissolution and absorption of retained dead foetuses in rats, noted that under-developed foetuses were better preserved than more mature foetuses retained *in utero* for the same period of time. He contended that as a foetal life progresses enzyme activity becomes more progressive and that in retarded foetuses the reverse obtains. This may be of importance as retarded foetal development may be a precipitating factor, leading to the death and dehydration of the one foetus of a twin pregnancy.

Thompson (1927) draws attention to the fact that unless the membranes are intact, the usual process of putrefaction takes place. With intact membranes the dead foetus is in a sterile medium and so, too, are its own respiratory and alimentary tracts, from which areas putrefaction usually occurs. She quotes in evidence the fact that if the limbs are removed from a cadaver at the time of death, putrefaction is very much slower in them as compared with that taking place in the trunk.

Kindred (1944) suggests that the dead foetus is surrounded by a fluid of maternal origin which replaces the liquor amnii and preserves the foetus in a desiccated and embalmed state.

Fluid is occasionally found in the amniotic sac of the foetuses.

CONCLUSIONS

1. The cause of intra-uterine death of one foetus in a multiple pregnancy and its preservation *in utero* is controversial.
2. Pressure by the viable twin is a probable factor.
3. The protective value of the intact membranes is shown by the lack of any effect on the health of the mother and surviving child.

SUMMARY

1. Two cases of foetus papyraceus are reported.
2. A brief review of the literature is given.
3. The possible clinical complications due to this condition are mentioned.

I wish to thank Prof. James T. Louw, of the Department of Obstetrics and Gynaecology, University of Cape Town, for his advice and interest in the preparation of this paper.

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DISSEMINATED SCLEROSIS IN AN INDIAN MALE

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This case of disseminated sclerosis occurred in an Indian male who has spent his whole life in Natal. Disseminated sclerosis is extremely rare in South Africa,¹ though a case in a non-European female was described in Johannesburg in 1947.² In other parts of Africa the disease is apparently also very rare, but two cases were reported from Kenya in 1946.³

As far as is known, this is the first case to be described in an Indian who has never left the borders of South Africa.

Khandasamy, a male Indian, age 51 years, married and with four children, was admitted to King Edward VIII Hospital on 19 July 1951. He was born in Natal and

has lived there all his life. He had formerly been employed ironing clothes in a laundry.

History. The patient's main complaint was inability to walk. Twenty-one years ago he developed pain in the hips and weakness in the left arm and leg, and 10 years later weakness of the right arm and leg. This weakness has been static and has not regressed. He denied at any time having suffered from blurred or double vision. There was no history of vertigo or paraesthesia and the patient had no complaints referable to the urinary or gastro-intestinal systems.

His mother is alive and well. His father died of 'fever' at the age of 70. His one brother and two sisters are alive

and well. Five brothers have died but the cause of death is not known. The patient denied that any member of his family has or has had similar symptoms to his own.

Clinical Examination. Mentally, the patient was reasonably intelligent. He was of a contented, happy nature, but did not show euphoria.

The physical examination revealed nothing abnormal except in the central nervous system.

Cranial Nerves. The pupils were regular and equal and reacted to light and accommodation. On ophthalmoscopy the discs were normal. Vision was 6/6 in both eyes. The fields of vision were full to hand testing. There was no weakness of eye movements. There was marked nystagmus on horizontal deviation of the eyes, equal to both sides, but no nystagmus on vertical deviation. Marked dysarthria was present, speech being staccato in nature. No other abnormalities of the cranial nerves were found.

Motor System. Tremor of the head was present. There was marked weakness of the left upper and lower limbs, with marked increase of tone and left ankle clonus. The right upper limb showed some increase of tone and some weakness. The right lower limb showed slight weakness, but no appreciable increase of tone. There was no wasting and no fasciculation. Reflexes were as follows:

	Right	Left
Triceps	++	++++
Biceps	++	++++
Supinator	++	++++
Abdominals:		
Upper	±	—
Lower	+	—
Knee	+	++++
Ankle	+	++++
Plantar	↑	↑

(+) = normal response

Sensory System. All four limbs showed gross ataxia with marked intention tremor. Adiadokinesis was present in the upper limbs, which also exhibited the rebound phenomenon. The arms fell away in a very short period of time on being held out while the eyes were shut. Ataxia of the lower limbs was so gross that even when the patient was supported by two assistants he could only take a few groping steps with difficulty.

On testing finger and toe movements, the sense of position was found to be normal in all four limbs. There was, however, some diminution of appreciation of the sense of vibration in both upper limbs and in the right leg. There was no loss of sensation to pin prick or cotton wool.

Lumbar Puncture. The fluid was clear and under a pressure of 120 mm. water. The pressure rose rapidly to 180 mm. water when the jugular veins were compressed.

LABORATORY AND RADIOLOGICAL FINDINGS

Cerebrospinal Fluid: Protein 40 mg. per 100 c.c.
Globulin, no excess.
Sugar 85 mg. per 100 c.c.
Chloride 700 mg. per 100 c.c.

The Lange colloidal gold test was not done in the absence of excess globulin.

Cells: 18 erythrocytes per c.mm.
2 lymphocytes per c.mm.

Organisms: *B. subtilis* only.

Wassermann reaction: negative.

Blood count: Haemoglobin, 109% (15.25 gm.%).

White blood cells: 8,400 per c.mm.

Polynuclears: 52%.

Lymphocytes: 41%.

Monocytes: 4%.

Eosinophils: 3%.

Blood sedimentation rate: 8 mm. per hour.

Blood Wassermann reaction: Negative.

Urine: Chemical and microscopic examination revealed no abnormality.

Chest X-ray: Nothing abnormal detected.

Skull X-ray: There was a calcified pineal gland, which was located in a normal position. No evidence of intracranial pathology was demonstrated. Lines drawn through the hard palate and the plane of the atlas vertebra were parallel, thus excluding platybasia.⁴

DISCUSSION

It is felt that this is an undoubted case of disseminated sclerosis. Other diseases considered, only to be dismissed, were:

1. *Neuro-Syphilis.* The normal cerebrospinal fluid findings, the negative blood Wassermann reaction, the absence of Argyll-Robertson pupils, the lack of dementia and the long duration of the disease were amongst the features against the diagnosis of tabo-paresis.

2a. *Friedreich's Ataxia.* The onset at 30, the increased tendon jerks and lack of family history precluded this diagnosis.

2b. *Other Familial and Hereditary Ataxias.* Most cases in this group are not associated with upper motor neurone lesions. Ferguson and Critchley have described a form of hereditary ataxia resembling disseminated sclerosis, in which there were signs of bilateral pyramidal degeneration and cerebellar inco-ordination in the limbs with dysarthria and an ataxic gait. However, their cases were familial and associated with external ophthalmoplegia. Also there was usually some anaesthesia and analgesia present.⁵

3. *Subacute Combined Degeneration.* The blood count revealed no anaemia. The age incidence was too early; there was no glossitis, no palpable spleen and there was no glove and stocking anaesthesia.

4. *Cervical Cord Tumour.* A lesion of the cervical cord might cause nystagmus and spastic ataxia, but would not cause dysarthria. There was only minor involvement of the posterior columns in this case with the ataxia mainly cerebellar in origin. Laboratory investigation revealed no abnormality of the cerebrospinal fluid. Queckenstedt's test gave a normal response. There was no involvement of the fifth cranial nerve to suggest an upper cervical lesion and no wasting in the arms or Horner's syndrome to suggest a lower cervical lesion.

Certain 'classical' features were absent in this case, viz. a history of remissions, bladder symptoms, temporal atrophy, a history of diplopia or blurred vision, euphoria and dementia; but then no case of disseminated sclerosis shows all the wide variation of common features.

In a special article in 1947, the National Multiple Sclerosis Society of New York presented a table of symptoms and signs in order of frequency of occurrence and this case showed the six most common features, namely:

1. Abdominal wall reflexes decidedly diminished or absent.

2. Chief complaint weakness and stiffness of one or both lower extremities.

3. Nystagmus (chiefly horizontal).
4. Babinski's sign present bilaterally.
5. Tremor present in the extremities (tremor present also in the head is not such a common feature).
6. Ataxia and adiadokinesis.⁶

It is interesting to speculate on the rarity of disseminated sclerosis in Southern Africa. In an address to the Southern Medical Association of America, Dr. Shields, a neurologist of Richmond, Virginia, had many pertinent observations to offer. He drew a parallel between the geographic distribution of the disease and the farm practices carried out in various areas where the disease is prevalent. He pointed out that there is a maximum incidence of the disease in countries such as Germany, England, United States of America and the states of Northern Europe, and that it is in these countries that large amounts of inorganic fertilizers are used. He maintained that these fertilizers cannot adequately replace all the requirements of the soil after intensive cropping and, in fact, upset the chemical balance of the soil. This results in the production of food with deficiency of elements such as cobalt, manganese and iron. This may result in diseases to animals and man. Apparently in New Zealand a soil deficiency of cobalt in the pasture grasses resulted in sheep becoming paralysed. The application of cobalt to the pasture prevented the paralysis from occurring. (In this connexion it is also interesting to observe the suggested association between copper de-

ciency in the soil and sway-back in sheep.) He further stated that cases were first described in England and France when the soil was being depleted. He contrasted this state of affairs with the absence of disseminated sclerosis in China, Japan and India, where natural fertilizers or manures are used.⁷

If this theory be the correct one, one wonders how long it will be before disseminated sclerosis becomes a fairly common disease in South Africa, where soil erosion is so widespread and where the feeding of a steadily increasing population will lead to the wider use of inorganic chemical fertilizers.

My thanks are due to Dr. J. L. Parker, Medical Superintendent, King Edward VIII Hospital, for permission to publish this case and to Dr. N. A. Rossiter, under whose care this case was admitted. I would also like to make acknowledgment to the Radiological Department, King Edward VIII Hospital, and to the Provincial Laboratory for X-rays and laboratory investigations.

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VENOUS MESENTERIC THROMBOSIS

REPORT ON A CASE WITH RECOVERY

E. KRUGER, M.B. CH.B.

Mine Hospital, State Mines, Transvaal

This case is presented in the hope of contributing something of value to the literature of vascular accidents. My purpose is to review briefly the subject of mesenteric thrombosis and to present a case which recovered.

Mesenteric vascular occlusion is often unrecognized before laparotomy or autopsy. It has been pointed out¹ that mesenteric thrombosis occurs more commonly than is often appreciated but in a milder form; this accounts for many vague abdominal symptoms in older people without there being necessarily a massive abdominal accident, e.g. where the intestinal circulation is impaired gradually. There is no place for conservatism in the treatment of this condition when it presents itself as an acute abdominal emergency. Radical surgery is the only hope in saving life.

Etiology. There is a number of predisposing causes but the exciting cause is still unknown.

The *predisposing causes* can be divided into general and local.

General:—

1. McClenahan and Fisher¹ reported 616 cases with 43 successful resections (or 7%) up to August 1947. Although the incidence of mesenteric thrombosis is greatest between the

ages of 30 and 70 years, it may occur at any age, but is extremely rare in children. It is more common in males. The rest of the causes are either *ascending* or *descending*.

The *ascending causes* are:

2. Venous thrombosis is most frequently associated with infections in organs or viscera that are drained by tributaries to the portal vein. Thus appendicitis, pelvic disease or ulcerating carcinoma of the colon may lead to venous thrombosis.

3. *Antecedent surgery*—surgery of the stomach, gall bladder, appendix, strangulated hernia and pelvis are predisposing factors. Here there are no inflammatory lesions in evidence, but injury to the vessel wall is a factor.

Descending Causes:

4. Other conditions which have led to thrombosis of the mesenteric vein have been blood diseases such as splenic anaemia; also trauma to mesenteric vessels; mechanical causes such as portal stasis from tumours or adhesions.

5. Many cases reported in the literature confirm the idea that in the history of patients who have primary mesenteric thrombosis due to atheromatous change in the vessels of the mesentery, there often was some abdominal distress, perhaps after a heavy meal, after some exertion, or at other times when the blood supply to the gut may be impaired.

6. In some cases no primary cause of thrombosis can be demonstrated. Vickery² suggests that in these cases the thrombi are bland in nature and that a partial volvulus with torsion of the mesentery could initiate the thrombotic process.

Local:—

1. Venous emboli, as opposed to arterial emboli, are practically non-existent.

2. Primary venous thrombosis, unlike arterial thrombosis, is quite rare. When it occurs it is due to endophlebitis or phlebosclerosis.

Prognosis. The prognosis of such a serious condition is, of course, grave as the lesion is usually extensive and tends to progress. The case mortality in all forms of this abdominal crisis is very high, because operation is not attempted in view of the general feeling by surgeons that the patient cannot tolerate surgery. Of all cases where operative procedure was performed the mortality rate is about 60%. Where nothing is done the mortality rate is about 90%; thus it would seem that surgery gives the patient about one chance in three to survive, while watchful waiting has little to offer but death. The prognosis in arterial cases is less favourable than in the venous ones, among which operative cures are extremely rare. The prognosis is influenced by:—

- (a) The length of bowel involved; and
- (b) Whether the bowel can be resected.

Anatomy and Pathologic Physiology. All blood collected into the veins of the abdominal part of the digestive tract passes into the portal vein by which it is filtered into the liver and then through the hepatic veins to the vena cava. A thrombus arising in the lumen of a vein may:

- i. Give off an embolus into the cephalic channels; or
- ii. Block off venous channels so that a descending thrombosis extending toward the bowel might occur.

When venous obstruction occurs, damming back and congestion follow, i.e. the infarction is haemorrhagic and not ischaemic in type.

The mesentery is dark as a result of haemorrhage. When gangrene is present there is usually a blood-stained ascites and the bowel is distended with blood. This is in contrast with the distension with gas seen in mechanical obstruction.³ Peritonitis is commonly the end result of the process, but perforation is relatively rare.

According to Benjamin,⁶ usually the lower parts of the jejunum and ileum are involved.

Clinical Picture. A review of the literature reveals lack of unanimity about the symptoms and physical findings in this condition.

1. Some authors state that continuous pain is a feature, others that pain is intermittent, though in 50% of cases colicky pain is experienced.

2. Some show concern about vomiting, others about the lack of it.

3. Bloody stools have been described.

4. Shock is usually present and varies with the degree of occlusion. Clearly no definite clinical picture is universally present and there are many variations in the presenting symptoms.

5. Goldman and Rives² report that the white cell count generally exceeds 20,000 per c.mm. This is higher than in most acute abdominal conditions. They also claim that, on X-ray examination, fluid in the small bowel, instead of gas, is likewise indicative.

6. The abdominal signs are tenderness, rigidity and distension.

Diagnosis. This is frequently made by exclusion. It is, however, rarely diagnosed pre-operatively.

Differential Diagnosis. It is most commonly mistaken pre-operatively for such conditions as:—

1. Acute intestinal obstruction.
2. Acute pancreatitis.
3. Acute cholecystitis.
4. Perforated peptic ulcer.
5. Diverticulitis.

Treatment. The most hopeful thing about mesenteric thrombosis is the fact that it can be cured by surgery. When actual gangrene of the bowel is present, immediate radical surgery is the only treatment. Resection is advocated as the most desirable surgical procedure. Resection must be sufficiently wide to remove oedematous bowel adjacent to the gangrenous area. There is no place for conservatism in the treatment of this condition. For extensive gangrene no other procedure is acceptable. It is easy to resect wide of the affected area of gut, but complete excision of the thrombosed mesentery is a different matter, for the superior mesenteric vein must not be approached too closely, and the trauma consequent on resection, however slight, is likely to produce a further spread of the thrombotic process centrally. It should be remembered that it is possible to resect 30% of the small intestine and still expect the intestinal tract to return to normal.

CONCLUSIONS

1. Radical surgery, i.e. wide resection and anastomosis, is the only tenable treatment where there is extensive gangrene of the bowel.

2. The condition often presents itself in a mild form, not always as a massive accident, as is commonly thought. Such a slowly progressive venous occlusion gives rise to a very different symptom complex.

3. Heparin and Dicumarol may possibly be of great value post-operatively. This, combined with the immediate treatment of shock and early surgical exploration, offers the best chance of recovery.

D'Abreu and Humble² recommend continuous heparin. They determine the amount of heparin to be given by the use of a heparin resistance test instead of the clotting time usually carried out. The titratable coagulability of the patient's blood was noted using heparin of diminishing strength. This method seems more accurate.

4. Benjamin⁶ recommends also the use of antispasmodics, e.g. papaverine.

CASE REPORT

The case described here appears to be unique, as complete recovery took place after an operation which consisted simply of a wide excision of the bowel with removal of a wedge of mesentery and end-to-end anastomosis without the recommended use of heparin to lessen coagulability of the patient's blood.

Intramuscular Penicillin and Streptomycin were given in the hope that it might deal with any systemic infection causing the thrombophlebitis.

Dempsey and Jones⁵ administered heparin and Dicumarol to one of their cases; this was not done here.

The patient, a middle-aged Shangaan, slightly built (weight 118 lb.) was admitted to the Government Gold Mining Areas Native Hospital on 28 August 1951, complaining of pain in the right iliac fossa. At the time a



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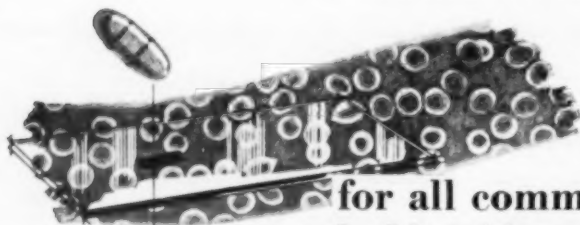
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definite diagnosis was not made though an acute appendicitis was suspected.

History: Present illness:—

Pain. This was the chief complaint. It started without warning on the previous day, when the patient came up from underground late in the afternoon after a hard shift's work as an electrician's boy. He was not very definite about the site, but later pointed with the tip of the finger to the right iliac fossa. This pain was at first intermittent and then of a continuous nature, of lancinating type, but not of very great intensity and made one suspect some form of parietal irritation. From time to time, however, he noticed exacerbations; this indicated peristalsis was taking place. The patient regarded the condition as having started suddenly. Though he did not complain much, the pain must have been quite severe because later he looked really ill, drawn and was sweating. This pain persisted for two days. At first it radiated over the pubic area, but later remained in the right iliac fossa.

Vomiting. He vomited involuntarily on two occasions the day before admission. The stomach contents were expelled, apparently with a certain amount of force. It was not urgent or large in amount and only contained food taken previously. The night before operation, i.e. on the fourth day, when his condition had improved much, he vomited again (bile).

Bowels. The patient had a normal motion before admission. There was no mucus or blood present. There was no arrest of flatus. He could not give any definite information about increased peristalsis, either visible, audible or palpable.

Hernia or Other Swellings in the Abdomen. There was no history of any being present.

Previous History. There were no previous attacks of a similar nature.

Clinical Examination: General:—Facies. On admission he did not really appear ill. His face was not pallid. His temperature and pulse were normal. On the morning of the fourth day he looked ill, his cheeks and eyes were sunken and he was obviously distressed.

Local: Inspection. The hernial sites revealed nothing. There was no distension present or limitation of respiratory movements. There was no increased peristalsis.

Palpation. He was tender in the right iliac fossa, but it was not very acute and the extent remained strictly localized and defined all the time. Overlying this area there was a definite voluntary rigidity. The muscles relaxed when his confidence was obtained. A soft, lumpy, ill-defined mass was felt in the right iliac fossa, apparently related to gut and not mobile. Rectal examination revealed nil.

Percussion. No more information could be obtained.

Auscultation. No borborygmi could be heard.

Special Examination. No enema was given as the patient was not constipated.

X-ray. A straight film of the abdomen on the next day revealed a vague and indistinct fluid level in the neighbourhood of the caecum. This was too inconclusive to permit of a laparotomy. No free gas was seen between the liver and diaphragm.

The blood count was as follows:—

Haemoglobin: 15.6 gm. %.
Colour index: 0.9.

Erythrocytes per c.mm.: 5,540,000.

Leucocytes per c.mm.: 12,400.

Neutrophils: 77%.

Monocytes: 9.5%.

Lymphocytes: 11.5%.

Eosinophils: 2%.

Basophils: —.

The red cells appeared to be hypochromic. There was a slight neutrophil leucocytosis.

Differential Diagnosis. On these findings alone we were not prepared to diagnose an acute intestinal obstruction and to operate. In view of the white cell count an acute appendicitis was suggested, but there was no pyrexia. It was decided to keep the patient under observation and administer antibiotics in the meantime; 500 c.c. 5% dextrose in saline was given intravenously and nothing given by mouth.

Treatment. The patient was operated on 4 September 1951, after a further 500 c.c. 5% dextrose in saline had



been given. The abdomen was opened under general anaesthesia (ethyl chloride and ether) through a right lower paramedian incision. All superficial vessels were ligated. On opening the peritoneum no blood-stained peritoneal effusion escaped, but a brownish-black and nearly gangrenous loop of gut about half-way down the small intestine presented into the wound. No apparent cause for this accident could be found on rapid examination. Adjoining this was a thick, oedematous, hard,

mesenteric mass. A rapid exploration revealed no other intra-abdominal abnormality. The blackened gut gradually shaded off on each side. The sections adjoining this were congested. A length of gut, about 2½ feet long, with as deep a wedge of mesentery as was deemed advisable, was then resected, the line of section being made about three to four inches away from any doubtfully coloured intestine at each end. An aseptic end-to-end anastomosis was performed and the gap in the mesentery closed. The abdomen was then closed without any drainage and the patient returned to the ward with an intravenous drip of 5% dextrose in saline and a Miller-Abbott tube with a Wangenstein suction apparatus attached to it. The patient left the table in a fairly good condition.

Pathological Findings. The specimen consists of a piece of ileum (cut from the specimen) bearing about three inches of mesentery. The gut has a dark plum colour (Fig. 1). This area merged imperceptibly into the healthy gut. The mesentery is very thickened, oedematous or doughy and the lymphatics very prominent. The small veins leading into the mesentery from the damaged gut contain recently clotted blood. The report on the tissue sent to the South African Institute for Medical Research read as follows:

'Section of this specimen of small bowel shows the presence of well-marked congestion, but no evidence of gangrenous change. Section of the mesentery shows the presence of fibrofatty connective tissue which is the seat of haemorrhage. Two of the larger venous channels are thrombosed, and one of these thrombi is undergoing organization.'

'The histological features are consistent with mesenteric venous thrombosis.'

Subsequent History. On the following day the abdomen appeared much less distended and the patient retained all liquids. Daily infusion and parenteral vitamin therapy were continued. The patient continued to improve from day to day. Stools were well formed and the appetite was good. The general condition of the patient remained good. There was no visible blood in the stools. Peristalsis propelled the intestinal contents through the anastomosis freely, whether fluids or solids were taken orally. The patient's further post-operative course was remarkably smooth and uneventful.

Dressing. This was not removed until the stitches were taken out.

Stitches. Alternate stitches were removed on the thirteenth day; the rest three days later.

Healing of the Wound. There was no delay in wound healing and the patient did not complain of any cramping abdominal pains. A solitary sentinel pile (external) began to worry him slightly the day before discharge.

Result. His bowels acted with a simple enema on the third day after operation and thereafter remained normal and regular. After the fifth day the Miller-Abbott tube was removed and a soft diet was begun. He became afebrile and remained so until the day of discharge. Solid food was introduced into the diet and the bowel seemed gradually to adjust. He gain 5 lb. in weight and appeared to have completely recovered from the abdominal vascular accident.

Subsequently he was put for one month on a light surface convalescent gang and was not seen again since the writing of this case.

SUMMARY

A successful case of resection of the small intestine for a case of idiopathic mesenteric venous thrombosis is described. The use of heparin is urged in cases of thrombophlebitis when dangerous complications are feared, as suggested by D'Abreu and Humble.²

Fluid, protein, electrolyte and vitamin balance were constantly watched in order to avoid the occurrence of any irreversible state.

My thanks are due to Dr. Alex Smith, the Senior Medical Officer, for permission to publish the case; to the pathologist of the South African Institute of Medical Research, Johannesburg, for the report on the tissue, and to the Librarian of the Witwatersrand Medical Library for supplying the references.

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VERENIGINGSNUUS : ASSOCIATION NEWS

MINUTES OF THE GENERAL MEETING OF THE QUEENSTOWN DIVISION (M.A.S.A.) HELD IN THE FRONTIER HOSPITAL ON THURSDAY, 4 OCTOBER 1951

Members Present: Drs. Botha, Everson, Holmes, Ingle, Knetsch, Kunz, Papilsky, Rosen, Schaffer, Schweitzer, J. van Schalkwyk, M. van Schalkwyk, var Zyl, Vellama, Wolpowitz.

Apology for absence: Dr. E. Louw.

Chairman: Dr. R. Schaffer, who was pleased to welcome Dr. Ingle (transferred from the Natal Coastal Branch) and Dr. Knetsch (stationed at the Glen Grey Mission Hospital).

The Late Dr. I. B. Gardiner: Members stood in silence as a token of esteem. The Secretary was requested to write to Mrs. Gardiner and convey the sympathy of the members.

Clinical Cases: 1. Dr. Everson showed an interesting nerve case with a history of trauma, plus physical and functional symptoms. The diagnosis was obscure. A long discussion followed, most members examining the patient and expressing an opinion. It was advised that the patient be sent to the Grootte Schuur Hospital and her progress be followed.

2. Dr. Botha showed skiagrams of a sarcoma of the tibia and of a syphilitic periostitis.

New Members: Dr. Ingle (transfer from Natal Coastal Branch), Dr. Knetsch.

Interns: Drs. Everson and van Zyl.

Business: Motor-car Insurance. Owing to the increase of premium, the Federal Council had taken up the matter and advised all members to insure with Edward Lumley of Lloyds, who have agreed to a smaller increase.

Medical Dinner. It was agreed, with one abstention, that a medical meeting and dinner be held in November. The committee formed to organize the dinner consisted of Drs. Schaffer, J. van Schalkwyk, Botha, Papilsky, Wolpowitz and Holmes.

Tea was served and the meeting terminated at 10.10 p.m.

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ANNUAL GENERAL MEETING OF THE QUEENSTOWN DIVISION (M.A.S.A.) HELD IN THE FRONTIER HOSPITAL ON 6 DECEMBER 1951

Members Present: Drs. Adendorff, Botha, Everson, Holmes, Ingle, Knietsch, Kunz, Louw, Papiisky, Rosin, Schaffer, Schweitzer, van Zyl, J. van Schalkwyk, Wolpowitz.

Apology for Absence: Drs. Paisley and Simonsz.

The Chairman (Dr. Schaffer) welcomed Dr. Adendorff from Dordrecht and Drs. Kunz and Knietsch from the Glen Grey Mission Hospital.

Financial Statement: Accounts 1 and 2 showed a credit balance. Account 3 (which was the Medical Dinner) showed a deficit of £19 5s. 9d. Dr. Schaffer explained that this was due chiefly to members who stated that they would be present at the dinner and then did not arrive; the number catered for had to be paid for. The members present agreed to liquidate the deficit.

Presidential Address: Dr. Schaffer said that he would shortly vacate the Chair. Since the new ruling that the President is the President-Elect, Dr. van Schalkwyk automatically becomes Chairman for the coming year. He had no intention of giving a presidential address but wished to make a few remarks. He thanked the members for their co-operation. During the year the Division had sustained two serious losses in the passing of Drs. Swemmer and Gardiner. He eulogized their good qualities. On the whole he thought that medicine had progressed in South Africa. The Hospital Ordinance had now been in force for some time and many of our fears had been unfounded and had been dispersed; there were still certain threats to the profession, but we had an active M.A.S.A. which has our interests in hand and will cope with any of our problems. The Border Branch is considered one of the most active of the Association. We had in the new secretary, Dr. Alexander, an interested and able man. He hoped that Branch officers would soon be considered.

Other subjects that Dr. Schaffer mentioned were:—

1. Appointment of full-time senior medical officers to hospital staffs.

2. Agency Departments of the M.A.S.A.

3. Insurance Agency of the Medical Association.

The Queenstown Division meetings had been mostly clinical and well attended. He again thanked all members for their support and loyalty. He had great pleasure in asking Dr. van Schalkwyk to take the Chair, and he was sure he would carry on very capably.

Dr. J. van Schalkwyk took the Chair amid applause and thanked his colleagues for the great honour. He would do his best to follow in the footsteps of Dr. Schaffer and do what he could for the Association. He felt he could always turn

to him for guidance and help. Ever since he had come to Queenstown he had been a very active member, especially in interesting himself in the meetings of the Border Branch and Federal Council. He had travelled to Cape Town, Johannesburg, Durban, East London, Umtata and other places to attend them. He expressed the sincere thanks of all the members to the past-president.

Election of Officers. President: Dr. J. van Schalkwyk. Vice-President: Dr. B. Wolpowitz. Honorary Secretary and Treasurer: Dr. D. Holmes.

Executive Committee: Drs. Papiisky, Ingle and Schaffer.

Border Branch Council: Drs. Wolpowitz, Botha, Ingle. President and Secretary *ex officio*.

Itinerant Practice: The minutes of a meeting of the sub-committee of Federal Council to consider the question of itinerant practice were read. The matter was open for discussion. Dr. Schaffer considered it unethical for a medical man to visit patients in a town where a practitioner is resident except with the knowledge of, or in consultation with, that practitioner.

Dr. J. van Schalkwyk associated himself with these remarks and thought itinerant practice undesirable.

Dr. Louw stated that the medical men were giving up their rights by allowing the S.A. Medical Council to interfere in the matter, and he thought that the Council should not interfere with the existing rights and liberties of the medical practitioner until such time as the Council defines what it means by 'itinerant practice'.

Dr. Ingle pointed out that itinerant practice is quite different from the occasional call to another village. The ruling refers to regular itinerant practice. Others entered into the discussion. Finally, Dr. Schaffer proposed, and Dr. van Schalkwyk seconded, that:

'In the opinion of this Division itinerant practice is unethical. The paying of regular visits to a town or a village in which another practitioner is resident and in practice shall be considered Itinerant Practice.'

Voting: Nine in favour and 2 against.

A vote of thanks was accorded to the Matron of the Hospital for providing refreshments at all the meetings during the year.

Dr. van Zyl thanked the members for their cordiality in inviting the interns of the Frontier Hospital to the medical dinner.

The meeting terminated at 9.45 p.m.

PASSING EVENTS

MEDICAL AID SOCIETY TARIFF

Owing to printing difficulties and paper shortage it has not been possible to distribute the new *Tariff of Fees* as early as was thought possible. The Head Office will endeavour to post copies during February.

MOTOR CAR INSURANCE FOR MEMBERS OF THE MEDICAL ASSOCIATION

Members are reminded that it will be to their benefit to reply to the circular recently forwarded to them with a newsletter. Doctors using their cars for professional purposes can effect a considerable saving in the premium to be paid by communicating with Messrs. Edward Lumley and Sons, P.O. Box 4639, Cape Town, the Association's official insurers for this class of motor-car insurance.

LONDON HOUSE 1951

Much progress has been made in the last 12 months. The whole of the Guilford Street frontage has been completed as well as the west wing, facing the old Caroline Place. This gives sleeping accommodation for 165 in the main building of London House. With annexes there is a total of 224 beds available for students. A new common-room, called the Churchill Room, has also been completed which, with the increased capacity, was very necessary.

There are now in residence 66 South Africans and, since the start of London House, a total of 351. In addition, there are 43 names on the books, either accepted for admission or on a waiting list. The following successes have been gained by South African residents during the past academic year:

1950:—October:	J. J. H. Rymer, M.R.C.S., L.R.C.P.
1951:—January:	P. Stemmler, F.R.C.S., Primary (Edin.).
	W. Grundill, F.R.C.S., Primary (Edin.).
February:	E. M. Barker, F.R.C.S., Primary.
March:	G. J. Sutin, D.C.H.
	P. Davies, L.D.S.
	S. B. du Toit, D.C.H.
	J. J. Geere, D.M.R. (Part I).
April:	A. C. Garnham, M.R.C.S., L.R.C.P.
	B. M. Jacobson, M.R.C.P. (Edin.).
	A. Berrett, D.M.R.D.
May:	N. F. Duncan, Dip. Town Planning (Lond.) and A.M.T.P.T.
July:	G. J. Sutin, M.R.C.P. (Edin.).
	P. K. Moxley, Dip. Town Planning (Lond.) and A.R.I.B.A.
	J. Grant, M.R.C.O.G.
	F. Daubenton, M.R.C.O.G.
	J. Pasvol, D.O.

A London House for women students and flats for married

students have now been begun. As a result of the Lord Mayor's National Thanksgiving Fund, a new Trust, the Sister Trust, has been formed to administer the money obtained from this Fund. Plans for a new building in Mecklenburgh Square are now in active preparation and this building will house women students and one portion of it will be flats for married students with or without children. As a short term plan, until this new building is ready, certain properties on the Foundling Estate are being used for this purpose and on 1 October of this year 2 houses were opened with a capacity of 30 single rooms; 3 flats have been decorated and furnished and let to married students.

Further information regarding London House and forms of application for admission to residence may be obtained from the Medical Secretary, P.O. Box 643, Cape Town.

Dr. M. L. Freedman, Director of Medical Services, Bechuana-land Protectorate, was awarded the O.B.E. in the New Year Honours List.

ELI LILLY MEDICAL RESEARCH FELLOWSHIP (SOUTH AFRICA)

The Honorary Secretary of the Cape Town Post-Graduate Medical Association wishes to draw the attention of medical practitioners registered in South Africa to the fact that applications for the 1952 award should reach him before 8 May 1952. Further details are published in this issue on page iii.

Dr. F. O. Fehrnsen recently retired from the post of Medical Officer of Health of the City of Cape Town. Dr. Fehrnsen comes from a long line of medical practitioners, both his father and his grandfather having been members of the profession. He was Medical Officer of Health for Cape Town for seven years and also served as Professor of Public Health at the University of Cape Town.



Dr. F. O. Fehrnsen

Dr. Fehrnsen undertook his training at the London Hospital and served in World War I in the R.A.M.C. as well as in the Navy.

Dr. Fehrnsen's appointments included that of Port Health Officer, Cape Town, as well as a period of general practice at Beaufort West.

REVIEWS OF BOOKS

DOUBT AND CERTAINTY

Doubt and Certainty in Science. A Biologist's Reflections on the Brain. By J. Z. Young, M.A., F.R.S. (Pp. 168 + vi, with 11 illustrations. 7s. 6d.) London: Oxford University Press, 1951.

Contents: 1. The Biologist's Approach to Man. 2. Brains as Machines. 3. The Human Calculating Machine. 4. The Establishment of Certainty. 5. How we Learn to Communicate. 6. The Changing Symbols of Science. 7. The Mechanistic Interpretation of Life. 8. Made in What Image? References. Index.

It will be a pleasure to many to have in book form the Reith Lectures broadcast by Professor Young during 1950. The gulfs which separate men of differing spheres of learning are one of the major disabilities of our fragmented, even asocial, society; the physicist has small common ground on which to meet the classical scholar, and Young himself states his fear that theologians and philosophers will dismiss much of what he, a biologist, has to say as simple-minded, because his ideas are not presented in the usual idiom of their systems. He has succeeded brilliantly in explaining the complex details of cerebral functioning to his listeners, many of whom are unaccustomed to scientific language. The lectures have been amplified by chapters of additional comment, and the ideas set forward in them are certainly important enough to deserve more careful attention than can be given to evanescent phrases issuing from a radio.

While he had intended merely to review the work at present in progress on the brain, Young found that his ideas crystallized into the hypothesis that man's thought can be organized most conveniently by focussing attention on the importance of methods of communication, and the way in which communication is ensured by the brain. He feels that it is in the development of means of communication within the species that man is most distinguished. Very extensive areas of the brain surface are devoted to the function of speech; communication with one's fellows is an activity of fundamental importance, meriting more extensive consideration from the biologist than it has received hitherto.

One of the greatest contemporary preoccupations is the attempt to correlate mind with body. While recognizing that 'the dualism of body and mind is perhaps the central problem of modern religion, philosophy and science', Young suggests (not altogether successfully) how we may be able to 'dispense with the concept of mind altogether'. He considers the increase of understanding which has resulted from the comparison of man with a machine, a clock in the seventeenth century and, in these more complicated times, with a calculating machine. The calculating machine probably has much to teach us about ourselves; nevertheless, there is a

great deal which the analogy fails to explain. There is not yet a clear relationship between the bodily functions which can be regarded as machine-like and those products of mind, imagination and emotion, which constitute the human personality.

Young's very cogent arguments need not be repeated here. It is of course true that man's communication with others is one of his chief methods for ensuring survival for himself and for his race. 'Whether we like it or not, we can be sure that societies that use to the full the new techniques of communication, by better language and by better machines, will eventually replace those that do not.' The contention is not to be disputed. The target-seeking, jet-propelled missile with an atom bomb in its tail is a most effective means of communication. However, it is what men seek to communicate to each other, and the motives which compel them, that is of crucial importance, and an adequate appraisal of which seems peculiarly lacking in Young's thesis.

The excellence of what Young says is not to be denied; it is what he omits to consider that is disturbing, the lack of understanding of the psychic accompaniments of existence, and the insistent although qualified suggestion that the actuality of human experience is anatomical and physiological. A man like Dante, for example, with his admonition: 'You were not born to live like beasts, but to follow virtue and knowledge' may be quite disinclined to accept Young's aim to be able 'to see the universe as a place we can talk about'. The biologist's view, many readers may find, lacks a satisfactory realization of man's complexity and the subtlety of his emotional life. The error into which Young is led is reflected in statements like the following: 'We shall be better able to train artists by study of the action of the brain than by talking about some quality called their imagination.' In one passage he talks of a painting as a means of communication; it is that, but one cannot be sure that Young considers how much more it is.

ENDOCRINOLOGY

Female Sex Endocrinology: Concise Therapy. By Charles H. Birnberg, M.D. (Pp. 134 + viii, with 30 illustrations including three in colour. 24s.) London: J. B. Lippincott Co. 1949.

Contents: 1. Woman as a Cyclic Phenomenon. 2. The Pituitary-Gonadal Relationship. 3. The Hormones of the Anterior Pituitary Gland. 4. The Hormones of the Ovary. 5. Puberty and Adolescence. 6. Diseases of the Anterior Pituitary Gland. 7. Menstruation. 8. Ovulation. 9. Disturbances of Menstruation. 10. The Climacteric. 11. Sterility. 12. Habitual Miscarriage and Threatened. 13. Mastalgia. 14. Hirsutism. 15. Laboratory Procedures in Endocrinology.

This small book fulfils the object intended by the author, to present in condensed form an outline of sex endocrinology.

He gives an outline of the basic principles—*anatomical, physiological and pathological processes dealing with each gland in turn.*

He correlates all the established facts with the clinical findings, in glandular diseases peculiar to women and on this, he bases his rational outline of treatment. Menstrual disorders,

sterility and its investigation, the menopausal disturbances, are dealt with quite adequately.

The busy practitioner and specialist will find this little volume of great practical value; it is a veritable mine of information. The book is very readable, well illustrated, its information reliable and the matter easily assimilable.

CORRESPONDENCE

COLLECTING ENTEROBIUS OVA

To the Editor: The scotch tape method of collecting the ova of *Enterobius vermicularis* is undoubtedly the best. However, the spreading of the scotch tape on the slide is apt to be a sticky, messy procedure. It can be much facilitated by the use of a minute drop of Benzol. This does not disturb the ova.

Amoebiasis Research Unit,
C.S.R.,
P.O. Box 1035,
Durban.
14 December 1951.

R. Elsdon-Dew,
Honorary Director.

MEDICAL PRACTICE WITHOUT REGISTRATION

To the Editor: I read, with interest, the letter of the Registrar of the S.A. Medical and Dental Council in the *Journal* of 8 December. According to this letter anyone (not registered) who, for gain, practises as a medical practitioner is liable to prosecution.

A man living at Irene examines sick people and sells them pills. Nearer where I live is a so-called 'Kanker Dr.'. He charges patients for admission to his nursing home.

Obviously the Act is either not applicable or else the Medical Council is turning a blind eye to what goes on.

The intention of the Act is partly to protect the gullible public. Could any of the *Journal's* readers inform me why so many quacks are allowed to continue to practise?

D. Henry.

44 Elands Street,
Welkom.
15 December 1951.

To the Editor: The letter by the Registrar of the S.A. Medical and Dental Council in the *Journal* of 8 December 1951 contains statements which, to my mind, are amazing. One is at a loss to understand how logic and the 'legal' mind of our colleagues on the Council actually work. I must refer to the sentence: 'Cases have also occurred where medical practitioners have come to South Africa at the request of particular patients in order to perform acts pertaining to the calling of a medical practitioner and they have performed these acts without being registered.'

We all are fully aware of the necessity of registration in accordance with the Act and one cannot argue with a law, even if we have not forgotten the axiom that 'the law is an ass'. But we must also remember that:

Est modus in rebus; sunt certi denique fines.

Quos ultra citraque nequit consistere rectum.

(The last word of this quotation was not used by Horace in the anatomical sense.) The liberal translation of the above is: 'Extremes of any kind are liable to lead to bigotry and tyranny.'

There is also a further warning by the Medical Council included in the last paragraph of this letter: 'Furthermore, it is both *illegal* and *unethical* for medical practitioners and interns who are registered by the Council to be associated with or assist at the performance of acts pertaining to the calling of a medical practitioner by unregistered persons.'

This is to my mind, being directed in this instance against qualified and illustrious medical men, an utter negation of all ancient practices which were accepted by the profession in all parts of the civilized world. From times immemorial it was customary by those who could afford it, to request eminent medical men from another country to attend to them in their illness. Nowhere in the world was any objection raised by the medical profession or any medical association against this practice, even if the patient was not a Monarch or Tyrant.

Moreover, those attending to the patient were actually eager to obtain the benefit of the experience and knowledge of the illustrious colleague for themselves and in the interest of their patient. It is therefore difficult to understand why we as registered practitioners should be liable to censure in such an instance. It certainly seems altogether illogical when we receive visits by illustrious colleagues from overseas, from whom we (including our University Professors and *horribile dictu* even members of the Medical Council) are anxious to learn. Such visitors were actually invited by the Universities to come to South Africa in the interests of medical education. The warning by the Medical Council actually implies that all those University Professors, lecturers, etc., who permitted these illustrious visitors to examine patients in their presence and who consulted with them, are guilty of both illegal and unethical conduct! The same applies to those practitioners who at the request and best interest of their patient, having before them that 'Salus aegroti supreme lex', adhering to the highest principles of the profession, are in the eyes of their colleagues on the Medical Council, guilty of a serious crime. This surely does not make real sense, at least not from a medical point of view. Have we arrived at crossroads and are taking the road leading to the wilderness? Have we forgotten our glorious past of helping suffering humanity (perhaps a platitude so often quoted by many for the benefit of only a few)?

It does not make much sense that the very same man (if visited by the patient) is a leading authority outside the borders of this country, but one of no status whatsoever the moment he crosses our borders. While nobody argues against 'Ordo est anima rerum' I just cannot comprehend that there is a real case for the Medical Council against me, should I request a visiting colleague, not registered here, to take a busman's holiday and advise me for the benefit of my patient and also myself. Let us try to come down to earth and (although logic is not one of the subjects of the medical curriculum, one could and would expect at least those honoured by their colleagues with their votes, that they make a special study of the subject and also of conditions prevailing in civilized countries overseas)—I am referring to Continental Europe long before the advent of Dictators—and make an attempt to adopt some of the similar good points here.

I feel that while it is logical to warn registered practitioners against association with unqualified practitioners, we have as yet never heard of any case against practitioners who actually contravene this regulation. Let the Medical Council first stop all associations with unqualified practitioners and not appear to be utterly illogical with similar warnings against association with fully qualified and in most instances renowned experts, who could and would be registered by the same Council. Surely the finances of the Medical Council are not so low, since we are compelled to pay the annual fee, that the few additional pounds for registration must be insisted upon. I have, however, not learned officially that the illustrious visitors we received during the war were registered, although some of them were actually requested to examine final-year students, which examinations are under the jurisdiction of the Medical Council.

Finally, I am prepared to be corrected for being wrong in stating that only a few months ago we were proud and delighted to have simultaneous visits by celebrities from Holland and Britain, who as far as I know have not been registered, whose lectures were attended by several members of the Medical Council, including the President himself, and with whom the Professors and other leaders of the profession were in close and intimate consultations at the General Hospital for the benefit of some unfortunate sufferers!

Difficile est satiram non scribere!

Johannesburg.
18 December 1951.

A CASE OF Q FEVER

To the Editor: A European aged 35 years, an engineer of a local factory, gave the following history:

On the evening of 13 September 1951 he complained of general malaise and said he felt as if he was getting influenza. He nevertheless went to work the following morning, but at noon he suddenly developed rigors, generalized body pains, and intense backache—as if iced water had been injected into the back under pressure.

I saw him first on the afternoon of 14 September 1951. His temperature was 102° F. There was well-marked photophobia. Apart from conjunctival injection, injection of the fauces and some generalized tenderness of lymph glands, physical examination was negative. A white cell count, done the next day, was 4,400 per c.mm. On the night of 14 September the patient developed a violent headache, which was retro-orbital in distribution, and was more marked on the right side. Throughout the next day intense headache in association with photophobia predominated as the main feature. Vomiting was early and persistent.

At this stage a tentative differential diagnosis was made between enteric fever, influenza and Q fever. The patient was started on Chloromycetin 500 mg. every 4 hours, but vomiting was so violent that it was discontinued after the third dose. On the night of 16 September delirium was first observed, and this became progressively more severe. The headache was so intense that the patient resorted to banging his head against the wall, this despite liberal administration of analgesics. Morphine was found to be the only effective sedative. The course of the illness tended to preclude the first two diseases in the differential diagnosis, and the resemblance of this case to the so-called 'atypical pneumonia' in army cases seen in Italy was most noticeable. These cases of 'atypical pneumonia' were probably Q fever.

On 18 September Aureomycin therapy, administered intravenously in view of the vomiting tendency, was instituted. This was given in 100 mg. doses (diluted in 10 c.c. of distilled water and given over a period of 5 minutes) every 2½ hours for a total of 6 doses.

On 19 September the patient felt subjectively much better, and was able to take a little food for the first time since becoming ill. He was also able to take Aureomycin by mouth. This was given in doses of 500 mg. every 6 hours. That night a persistent, unproductive cough developed, and the patient complained of a feeling of tightness in the chest. No physical signs were detected.

The temperature which had fluctuated between 101° F and 103° F throughout the illness, reached normal on the morning of 20 September and, apart from a slight cough, he was then symptom-free.

The pulse rate was slow throughout, and despite the fever, never rose above 108 per minute.

In all, the patient was given a total of 12 gm. of Aureomycin. Convalescence was prolonged, marked physical weakness persisting for several weeks after the illness.

Laboratory Diagnosis. Blood for the Q fever complement fixation was taken on 18 September and was reported by the S.A.I.M.R. to be negative. As it was felt that it was perhaps too early to expect a positive result, a second specimen was taken on 30 September and sent to Prof. van den Ende of Cape Town, who reported the specimen as giving a positive reaction for the complement fixation test for Q fever.

The wife of the patient developed identical early symptoms on 26 September. She had nursed the patient throughout his illness. She was treated with Aureomycin orally and responded to the treatment in one day. Her blood, taken 3 weeks later, gave a negative response to the complement fixation test for Q fever.

Discussion. In retrospect, certain features of this case (the conjunctival injection, the bradycardia and the early delirium) should have pointed to the inclusion of Weil's disease in the differential diagnosis. The urine was consistently bile-free, however, and the liver was not palpable or tender. This was especially watched in view of the fact that the patient had had a severe bout of infective hepatitis in June 1950.

Derrick (1937), in a survey of 9 cases in Australia, gave the first description of Q fever as a clinical entity. He stressed the intense headache, the slow pulse rate and the acute progress

of the disease, as being characteristic. Conjunctival injection, if present, he considered very suggestive, provided leptospirosis was excluded. He found persistent vomiting in 2 cases. Vomiting was a troublesome feature of the case described above, and I feel that if Aureomycin for intravenous administration had not been available, antibiotic therapy would have been precluded.

It seems reasonable to assume that the wife of this case also had Q fever, which was, however, aborted by early Aureomycin therapy before a positive serological reaction could develop. The incubation period (13 days) appears to substantiate this supposition (Deutsch and Peterson, 1950).

Specific diagnosis appears to be possible only in retrospect, as evidenced by the finding of a negative complement fixation test on the fifth day of the illness, and a positive reaction 12 days later.

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Deutsch and Peterson (1950): *J. Amer. Med. Assoc.*, **143**, 348.
'Glen Ewan,'
Howick,
Natal.
17 December 1951.

KHELLIN IN WHOOPING-COUGH

To the Editor: The value of Khellin* (Visamin in the U.S.A.) in the treatment of the paroxysmal stage of whooping-cough does not seem to be as widely known as it ought to be.

This drug causes conspicuous and long relaxation of all visceral smooth muscle—the intestines, uterus, bile-ducts, bronchi and especially ureters (Anrep *et al.*, 1947).

While Chloromycetin, Aureomycin and Terramycin are effective against *H. pertussis*, the response of the spasms of coughing is often not dramatic. It is the great stresses caused by the spasms which are responsible for the most important complications, not excepting the strain on the parents.

Khalil and Safwat (1950) report good results and state that the number of paroxysms, and their intensity and duration are greatly and rapidly reduced. It appears that this claim is a sound one, and that although the frequency of the cough may remain relatively unaffected, the frequency and the force of the paroxysms are minimized.

The dose is 5–7 mgs. per kg. body weight per day, given in divided doses every 6–8 hours.

For practical purposes this means that the dose is:—

Age	
0–3 months	— ½ tablet every 6 hours.
3–6 months	— ½ tablet every 8 hours.
6–12 months	— ½ tablet every 6 hours.
1–3 years	— 1 tablet every 8 hours.
4–6 years	— 1 tablet every 6 hours.
6–10 years	— 1½ tablets every 6 hours.

The tablet is assumed to be of 25 mg. weight. It is soluble in water and may be given in syrup.

The effects are cumulative and the administration should continue for 5–7 days. It may be resumed later without prejudice.

No toxic effects have yet been seen, but are said to be mild and confined to nausea, which responds to caffeine or hyoscine.

* Benecardin (Benger); Ammicardine (The Alpha Laboratories, Cairo).

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406 Southern Life Buildings,
St. George's Street,
Cape Town.
22 December 1951.

Peter V. Suckling.

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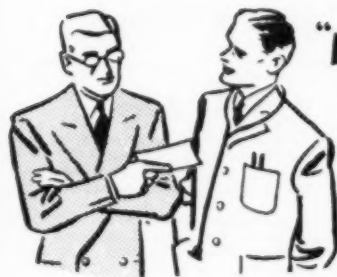
It is proposed to hold a postgraduate course in NEUROLOGY and NEURO-SURGERY at The National Hospital, Queen Square, from the 26th May to the 12th July, 1952.

The course will include a series of lectures and demonstrations on neurosurgical, neurological, and ancillary subjects: clin-

ical demonstrations; and attendance at outpatient clinics. Attendance at operations may also be arranged at the discretion of the Surgeons.

Special guest lectures will be given by distinguished neurosurgeons and neurologists from the United Kingdom and from Abroad.

Fee for the course is £21.0.0. Applications for places should be made to The Dean, Institute of Neurology, The National Hospital, Queen Square, London, W.C.1., England.



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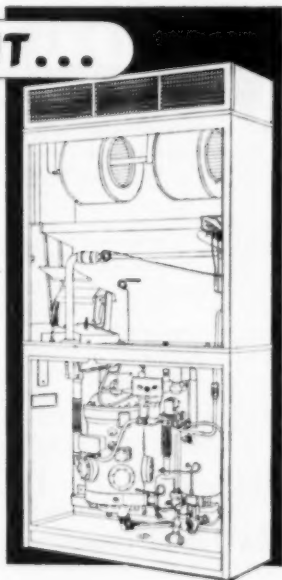
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UNION MEDICAL SUPPLIES
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ANNOUNCEMENT

In furtherance of our policy to provide a complete pharmaceutical and surgical service to the medical profession, **Petersen Ltd.** have pleasure in advising that they have recently acquired the business of—

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as from 26th January, 1952



Instructions to Authors

All authors are advised to consult *Medical Writing*, by Dr. M. Fishbein, formerly Editor of the *Journal of the American Medical Association*. The volume is obtainable from medical libraries in South Africa. It is published by the Blakiston Co., Philadelphia, U.S.A.

Papers submitted for publication in this *Journal* are accepted on condition that they have not been published elsewhere. The *Journal* Management reserves the copyright of all material published.

Considerable delay in the publication of papers is often due to the fact that they are poorly prepared. Publication will be expedited if the following specifications are complied with:—

1. All copy should be typewritten (double or preferably triple spaced) with wide margins.

2. Tables, references, graphs, illustrations and legends for illustrations should be clearly identified and prepared on separate sheets.

3. All photographs should be glossy prints unmounted, untrimmed and unmarked. Authors' suggestions for trimming, etc., are most suitably indicated on a duplicate print or diagram.

4. In no circumstances should original X-ray films be forwarded. Glossy prints must be submitted.

5. Line drawings should be on white board, arranged to conserve vertical space. All lettering in diagrams and graphs should be indicated clearly in soft lead pencil, preferably on a duplicate specimen or diagram in rough. In no circumstances should lettering be inked in or typewritten on the figure or the graph. Illustrations should not exceed 12 inches x 18 inches in size.

6. Figure numbers should be marked clearly on the back of each illustration, and in every case the top of the illustration should be indicated.

7. A limited but reasonable amount of illustrative and tabular matter is allowed free. Additional material of this sort may be allowed at cost, at the discretion of the Editor.

8. All references to the literature should be inserted in the text as a superior number and listed at the end of the article in numerical order.

9. References must conform to the following convention (journal titles being abbreviated according to the *World List of Scientific Periodicals*):—

White, J. and Brown, A. B. (1946): *Arch. Clin. Med.*, **123**, 167.

Books should be cited as follows:—

Smith, J. (1946): *An Introduction to Medicine*, 2nd ed., p. 174. Cape Town: John Black, Ltd.

10. All numerals to be printed as figures (i.e. not spelt out). For 'one' or 'I' always follow copy. All numerals always to be spelt out in full at the beginning of a sentence.

All numerals always to be spelt out in full at the beginning of a sentence.

11. Cubic centimetre as c.c.; Cubic millimetre as c.mm.; 7.11.46 as 7 November 1946; 2nd as second; 10/6 as 10s. 6d.; Per cent. as %; 1" as 1 inch; B.P. 140/80 as Blood pressure, 140/80 mm. Hg.

12. Each paper should conclude with a summary (of about 200 words) intelligible apart from reference to the main text of the article.

13a. Galley proofs will be forwarded to the author in good time before publication date.

13b. Corrections, other than typographical errors, will be charged to the author. It is therefore most important that the MS. be submitted in its final form.

14. Reprints: An order blank for reprints, together with a price list, will be sent to the author as soon as his article reaches page-proof stage.

15. All manuscripts and correspondence should be addressed to:—The Editor, *The South African Medical Journal*, P.O. Box 643, Cape Town.

Provincial Administration of the Cape of Good Hope

HOSPITALS DEPARTMENT

HOSPITAL BOARD SERVICE: VACANCIES

Applications are invited for the undermentioned vacant posts in the Hospital Board Service.

The appointment of the successful candidates will be made in terms of, and be subject to, the Hospital Board Service Ordinance, 1941 (Ordinance No. 19 of 1941) and the regulations framed thereunder.

In addition to the emoluments specified hereunder, cost-of-living allowance is payable to whole-time officials and employees.

Applications should be submitted (in duplicate) on the prescribed form Staff 23, which is obtainable from the Director of Hospital Services, P.O. Box 2060, Provincial Building, Wale Street, Cape Town, or from the Branch Representative of the Hospital Department at Cape Town (P.O. Box 1487), Port Elizabeth (P.O. Box 80), East London (P.O. Box 13), Kimberley (P.O. Box 618), and Umtata (P.O. Box 202), or from the Medical Superintendent of any Provincial Hospital or Secretary of any School Board in the Cape Province.

The closing date for the receipt of applications is 9 February 1952, and applications should be addressed to the Branch Representative, Hospitals Department, P.O. Box 1487, Cape Town.

Institution	Post	Emoluments	Additional qualifications and remarks
Somerset Hospital	Medical Practitioner Grade 'A' (Surgery)	£500-600-720 p.a.	(4774)

Required

Medical officer required for examination of factory employees. The duties will include a monthly check of all employees. This examination will take place at our factory. The fees payable for these services will be in accordance with those laid down by the Medical Association of South Africa. Apply Oldham & Son (Africa) Limited, P.O. Box 15, Benoni South.

(This advertisement has been approved by the East Rand Branch of the Medical Association of South Africa.)

For Sale

Established physiotherapist's practice with good connections in new medical building in Johannesburg. Present owner wishes to retire due to health reasons. All equipment included in price of sale. Suite includes: reception room, consulting room, 2 treatment rooms with dressing cubicles, shower and steam baths, lavatory. Centrally heated, fitted Venetian blinds. Reasonable rental. Two practitioners could share. Principals only. Write to 'A. K. K.', P.O. Box 643, Cape Town.

Assistant Required

Assistant with surgical experience for a large practice in a Reef town. Prospects for suitable candidate. Details on application. Apply, stating qualifications, age, experience, religion and when able to start. Write to Local Agency Manager, Medical House, 5 Esselen Street, Johannesburg.

Partner Required

Medical practitioner in established Transvaal country practice requires partner. Must be experienced in surgery and fully bilingual. Please furnish full details of experience and references in writing. For further particulars write to 'A. K. G.', P.O. Box 643, Cape Town.

Required

Part-time medical officer wanted for a factory in Springs. Duties to commence 9 February 1952. Details may be had from the undersigned to whom applications should be sent by 1 February 1952.

Works Secretary, P.O. Box 564, Springs.

The Medical Association of South Africa Die Mediese Vereniging van Suid-Afrika

AGENCY DEPARTMENT : AGENTSAP AFDELING

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PRAKTYKE TE KOOP : PRACTICES FOR SALE

(673) Natal. Average gross receipt £1,650 p.a. Prescribing. Premium required £1,275. One appointment £200 p.a. Good scope for expansion. Double-storied seven-roomed house situated on 1½ acres and separate surgery building for sale at £6,500. Surgery may possibly be rented by arrangement at approx. £8 p.m. Picturesque surroundings. Climate notably cooler than that of the coast.

(746) Large dispensing practice, mainly non-European. Average annual cash receipts approx. £5,200. £5,500 required for premium, drugs and surgery furniture. Details on application.

(350) Eastern Cape Hospital town. Total gross receipts preceding 13 months, £3,700. One appointment. Premium £1,500. House for sale at £3,000. Large bond available. £700 rebate if appointment not transferred. Practice offers great scope for practitioner with surgical ability.

(895) Partnership share in specialist physicians' practice. Details on application.

(918) Eastern Province solus practice. Premium required £1,400 (includes drugs, surgery furniture, instruments and goodwill). Payment £750 cash, balance over two years.

(877) Cape Midlands. Exceptionally well-established solus prescribing practice in progressive inland hospital town. Good deal of surgery done. Average annual receipts approx. £6,200. One appointment. Premium required £3,000. House for sale at £4,000. Terms could be arranged. Good schools. Willing to give thorough introduction.

(925) CAPE TOWN, Southern Suburbs. Practice for immediate sale. Gross takings were approx. £1,200 p.a. plus income from one appointment amounting to approx. £150 p.m. Furnished consulting rooms available to rent. Nominal premium. Details on application.

Large general practice, eminently suited for a woman. Details on application.

VENNOOTSAP VERLANG : PARTNERSHIP REQUIRED

(811) Partnership share in Cape or Natal in predominantly English-speaking practice with min. net income £2,500 p.a.

MEDICAL EQUIPMENT FOR SALE

(772) Strand, C.P. Dressing tables, cupboards, waiting-room furniture and instruments.

(758) Electrocardiograph. Sanborne Cardiette. Weight 24 lb. Perfect working condition. Used by Cape Town specialist physician. £160 or nearest offer.

(674) British Encyclopaedia of Medical Practice.

(878) White wooden cabinet for surgery. Five feet high. Top half glass doors and shelves. £23 10s.

(909) Slit Nitra Lamp (Prof. Gullstrand's). Good working order. £20 or nearest offer.

CONSULTING ROOMS REQUIRED

(907) Cape Town. Two rooms and share waiting room and services of nurse/receptionist. Urgent.

JOHANNESBURG

Medical House, 5 Esselen Street. Telephone 44-9134-5, 44-0817
Mediese Huis, Esselenstraat 5. Telefoon 44-9134-5, 44-0817

PRAKTYKE TE KOOP : PRACTICES FOR SALE

(Pr S34) Progressive Transvaal town dispensing practice. Average gross income £3,500 p.a. Excellent surgical facilities. Owner going overseas.

(Pr S31) O.V.S.-praktyk. Goeie geleentheid vir algemene geneesheer met aanleg vir swywerk. Alle fasiliteite. Medisyne word aangemaak. Moet tweetalig wees. Jaarlikse inkomste £2,400. Eienaar gaan verder studeer. Premie vir klandisie-waarde, instrumente en voorrade, £1,500. Een maand introdukcie sal gegee word.

MEDICAL EQUIPMENT

(1019) Zeiss microscope. Condition as new. £55.

(1023) Heavy based Irrigator stand, height adjustable, complete with glass flask and hook to carry vacolitre flasks. £7.
(1024) Bausch & Lomb microscope. Condition as new. Oil, high and low power lenses. Two eye-pieces. £60.
(1026) B.G.E. 'Hanovia' Ultraviolet lamp. Good condition. £25.

ASSISTENTE VERLANG : ASSISTANTS REQUIRED

(A 030) O.F.S. District Surgeon and General Practitioner requires assistant. View to partnership. Salary to be arranged.
(A 031) Assistant with surgical experience for a large practice in a Reef town. Prospects for suitable candidate. Details on application. Apply, stating qualifications, age, experience, religion and when able to start.

VENNOOTSAP VERLANG : PARTNERSHIP REQUIRED

(P W29) F.R.C.S. recently done two years' P.G. work, extensive experience as General Practitioner, tropical medicine, interested in doing surgery for a G.P. firm.

DURBAN

112 Medical Centre, Field Street. Telephone 24049

PRACTICES FOR SALE

(D1) In large coastal town suitable for a F.R.C.S. or M.R.C.O.G. Total gross receipts from June 1950 to June 1951, £4,995. Premium £3,100 includes drugs, fittings, surgery furniture and instruments. Terms could be arranged with reasonable cash deposit. Owing to ill-health owner wishes to sell immediately.

(D4) Natal midlands. Premium £1,500 includes drugs and surgery furniture. Very reasonable deposit and balance on easy monthly terms. D.S. appointment but a rebate of £400 will be made if the appointment is not transferred to the purchaser. This is a dispensing practice, 75% Native. House to rent at £12 per month.

LOCUM REQUIRED

(D1.1) Stanger, Natal, for February and March 1952. £2 2s. per day, plus travelling expenses, board, lodging and laundry. If locum uses his own car, free petrol, oil and £10 per month car allowance. General Practice. Knowledge of Afrikaans essential. Alternate week-ends and alternate nights off. Single man preferred.

For Sale

Well-established practice in Eastern Free State with modern hospital and maternity home facilities. Gross income for previous 12 months £4,700.

Price £2,000, including complete stock of instruments, medicine and furniture. Apply to 'X. Y. Z.', 1 Browne Street, Bloemfontein.

Te koop

Goed gevestigde Oostelike Vrystaatse praktyk met moderne hospitaal- en kraaminrigtingfasiliteite.

Gros inkomste afgelope 12 maande, £4,700.

Prys: £2,000, insluitende volle voorraad instrumente, medisyne en meubels. Skryf aan 'X. Y. Z.', Brownestraat 1, Bloemfontein.

Services Offered

Doctor and wife (trained nurse) proceeding United Kingdom between April and June 1952, willing to look after invalid on voyage. For further particulars write to 'A. K. J.', P.O. Box 643, Cape Town.

BRASS PLATES

TO MEDICAL COUNCIL SPECIFICATION

VICTOR C. GLAYSHER

165 BREE STREET
CAPETOWN

PHONE
2-5111

Vacant District Surgeoncies

Applications for the undermentioned District Surgeoncies, accompanied by full particulars as to date and country of birth, qualifications, experience and previous and present appointments of the applicants and the earliest date on which they can assume duty, if appointed, should reach the Secretary for Health, P.O. Box 386, Pretoria, not later than 15 February 1952. Testimonials (copies) may be submitted, but the Minister of Health wishes it to be known that any candidate will be regarded as disqualified who directly or indirectly canvasses for appointment.

The appointments are on a part-time basis and private practice is not precluded.

Applicants should state whether they have a knowledge of both official languages, also whether they are competent to diagnose leprosy and venereal diseases and to use the modern intravenous and other therapeutic technique in the treatment of venereal disease. Applicants should also state whether they have any experience as a medical officer of health or in any similar capacity. If more than one post is applied for, a separate application should be submitted in respect of each:

Place	Salary per Annum £	Drug Allowance per Annum £
Cape Province		
Jamestown	250	25
Darling (Malmesbury)	150	15
Tulbagh	250	20
Franschhoek	359	20
Orange Free State		
Rosendal	400	25
Fauresmith	420	60
Lindley	250	40
Transvaal		
Brits	650	100
Alldays (Zoutpansberg)	350	25
Springs	570	*
Amersfoort	300	40
Volkstrust	350	60

* Drugs supplied under contract.

The salaries cover all ordinary and routine services, but travelling allowance of 1s. per mile for all mileage travelled outside a radius of three miles from headquarters, night detention at 15s. and supplementary fees for certain other services will be payable. Also fees for attendance at courts and inquests in accordance with the tariff of the Department of Justice.

Forms of application and copy of draft agreement will be furnished on application.

(33144)

Wanted

Assistantship with view to partnership offered in large partnership practice in pleasant Transvaal hospital town with all facilities. Salary £70 per month, plus transport allowance. Reply stating experience, religion, etc., to: 'A. K. B.', P.O. Box 643, Cape Town.

Required

Woman doctor (27), graduated December 1949, seeks surgical assistantship. Experience: internship overseas, further 6 months' accident work at Radcliffe Infirmary, Oxford. At present holding an obstetrical post. References and testimonials available. Telephone 6-6830, Cape Town, or write to 'A. K. H.', P.O. Box 643, Cape Town.

Kromboom Nursing Home, Rondebosch, C.P.

A newly built luxury nursing home in one acre of garden; large covered stoeps; mountain view. For all medical, convalescent and maternity cases. Resident doctor. Terms from 22s. 6d. a day. Telephone 6-6627.

South African Railways and Harbours Sick Fund

APPOINTMENT OF RAILWAY MEDICAL OFFICER: WYNBERG

Applications are invited from registered medical practitioners for the position of Railway Medical Officer, Wynberg, at a salary of £1,160 per annum, plus the fees and allowances prescribed in the Regulations of the Sick Fund, and with the right of private practice.

The salary will be subject to adjustment in accordance with the census of members to be taken on 1 April of each year.

The appointment will be made in terms of the Regulations of the Sick Fund, and will be subject to termination on four months' notice being given by either side.

The successful applicant will be required to reside at Wynberg, to take up the appointment on a date to be arranged, and to carry out his duties in accordance with the Regulations of the Sick Fund.

Applications should reach the District Secretary, Cape Western District Sick Fund Board, Security Building, Exchange Place, Cape Town, not later than 28 February 1952, and should state:

1. Full name.
2. Qualifications (when and where obtained).
3. Experience (when and where obtained).
4. Date of birth.
5. Country of birth.
6. Whether married or single.
7. Whether fully bilingual.
8. Whether South African citizen.
9. What Government appointment, if any, is held.

Canvassing by or on behalf of any applicant is liable to disqualify such applicant.

Any further particulars required may be obtained from the District Secretary at the above address, on application.

P. J. Klem

General Secretary
(36)

Johannesburg
26 January 1952

Public Service Commission

VACANCIES IN THE PUBLIC SERVICE

1. The attention of medical practitioners, registered with the South African Medical and Dental Council, is drawn to an advertisement appearing in the *Government and Provincial Gazettes* of this week, inviting applications for the under-mentioned posts:—

Post	Department/ Administration	Salary Scale £
Medical Officer	Pensions (Cape Town)	960 × 40 — 1,120
District Surgeon	Health (Bronkhorst-spruit)	960 × 40 — 1,120
Medical Officer	South West Africa Administration (Ondangua, Ovamboland)	900 × 40 — 1,020

2. In addition to salary a cost-of-living allowance at the rate of £256 per annum (married) and £80 per annum (single) is payable at present.

3. It is emphasized that full and detailed particulars of qualifications and previous experience (including military service) must be furnished, but original certificates and testimonials should not be submitted. Application forms (Z.83 and P.S.C. 8 (a)) are obtainable from the Secretary, Public Service Commission, Pretoria, to whom filled-in forms must be addressed.

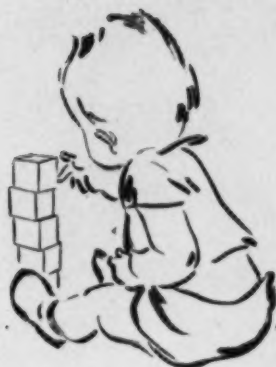
4. The salary scales attaching to the above-mentioned posts are under review. Revised and probably improved scales will be announced in due course.

5. The closing date for the receipt of applications is 16 February 1952.

(32967)



ideal for infants and children



'ESKACILLIN' 50 is a palatable, easily administered, liquid penicillin for oral use. Its delicious flavour makes it the ideal oral penicillin for young patients and for those who dislike tablets or bitter mixtures. The administration of this palatable and stable form of penicillin obviates the necessity of injections—a notable advantage in the treatment of infants and children, especially when repeated exhibition of penicillin is indicated.

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Di-Paralene is indicated in the symptomatic relief of urticaria, hay fever, itching atopic dermatoses, and in certain cases of vasomotor rhinitis and sinusitis, and certain cases of asthma.

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